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GOVERNOR'S TASK FORCE ON THE MENTAL HEALTH OF JUVENILE OFFENDERS

Milton J. Shapp,
Governor
COMMONWEALTH OF PENNSYLVANIA

June 1978


SEAL OF THE STATE OF PENNSYLVANIA

Governor's Task Force on the Mental Health
of Juvenile Offenders

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I. LEGAL BASE



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strial bank, credit union, trust company, bank and trust banker, building and loan association, or other financial business in Pennsylvania, or employer who or which he provisions of section 487 of this act, or who or which ıy false or misleading statement in connection with any d by said section, shall be guilty of a misdemeanor, and hereof, shall be sentenced to pay a fine not exceeding ars ($1000).

, July 9, P.L. 993, No. 202, § 8, effective in 60 days.

RTICLE V. STATE BLIND PENSION

y

t shall provide a State blind pension to any blind person

Pennsylvania;

inmate of any penal institution or hospital for mental

l annual income of his own of less than three thousand rs ($3600);

or personal property of a combined value of not more ınd five hundred dollars ($7500); and who

isposed of any property without fair consideration within nmediately preceding the date of application for State while receiving such pension, if ownership of such prop- ith his other property, would render him ineligible for

eiving supplemental security income for the aged, blind suant to Title XVI of the Federal Social Security Act.[1] o the determination of eligibility for State blind pension, property shall be deemed to be its assessed value minus it in no case shall the assessed value be more than the official market value; the value of personal prop- emed to be its actual value; and interest in property itireties shall be deemed to be a one-half interest. De- ne amount of an applicant's income and the value of his e made by the department without regard to any Fed- gulations respecting income and resources of applicants lind. The valuation of real property for the purposes nall not be increased by reason of reassessment, except at the real property has been actually enlarged or im- ination of the amount of an applicant's income shall rease in (i) social security payments to him provided aw and taking effect subsequent to January 1, 1971; tirement benefits provided to him under the Railroad of 1937, 45 U.S.C. § 228 et seq., and taking effect sub- ary 1, 1976, and (iii) veterans' benefits provided to him d by the Veterans' Administration and taking effect nuary 1, 1976.

1, Dec. 29, P.L. 634, No. 168, § 1, imd. effective; 1973, 06, No. 143, § 4, effective Jan. 1, 1974; 1974, Dec. 26, 24, § 1, effective Oct. 1, 1974; 1976, July 9, P.L. 540, nd. effective; 1977, June 21, P.L. 18, No. 14, § 1, imd.

.C.1954) § 1 et seq.

: In clause (3), raised less than three thou- l dollars from three

: In last sentence of serted "(i)" preceding words "social security payments", and added clause (ii).

1977 Amendment: In last sentence, inserted phrase "and taking effect subsequent to January 1, 1976" in two places.

§ 507. Amount of Pension

Except as provided for payment for nursing home care, the amount paid after the effective date of this act to an eligible blind person having actual annual income of his own of two thousand five hundred eighty dollars ($2580) or less shall be eighty-five dollars ($85) monthly, and the monthly amount paid to any other eligible blind person shall be fixed in such amount that the sum of his actual annual income and State blind pension equals three thousand six hundred dollars ($3600) a year.

As amended 1971, Dec. 29, P.L. 634, No. 168, § 1, imd. effective; 1974, Dec. 26, P.L. 991, No. 324, § 1, effective Oct. 1, 1974.

1974 Amendment: increased actual annual income to two thousand five hundred eighty dollars from one thousand nine hundred eighty dollars, following "of his own", and to three thousand six hundred dollars from three thousand dollars following "State blind pension equals".

§ 509. Medical assistance and burial

Persons receiving State Blind Pensions shall be eligible for burial assistance and, under the medical assistance program of Article IV,[1] for payment of home and office visits of physicians or chiropractors, prescribed drugs, dental care, vision care provided by a physician skilled in diseases of the eye or by an optometrist, ambulance service and visiting nurse service.

As amended 1968, July 31, P.L. 904, No. 273, § 8.

[1] Section 401 et seq. of this title.

§ 511. Application

(a) Every person applying for State blind pension shall be required to sign a statement setting forth the nature and amount of his income, the nature and value of his property, and such other facts as may be required by the department in order to determine whether he is eligible for State blind pension. Every such applicant shall make affidavit that the facts set forth in such statement are true and correct. Every person employed in the department who has power to administer oaths for any purpose shall have power to administer oaths for the purpose of carrying into effect the provisions of this section.

(b) Whenever a blind person is unable to make application for State blind pension by reason of his illness or infirmity, application on his behalf may be made by a relative or by an official of any institution in which he is receiving medical care. Such application shall contain the statements required in subsection (a) of this section except that such applicant shall be permitted to make affidavit that the facts set forth in such statement are, to the best of his knowledge and belief, true and correct.

As amended 1968, July 31, P.L. 904, No. 273, § 8.

Act 148

ARTICLE VII. CHILDREN AND YOUTH

(a) DEPARTMENTAL POWERS AND DUTIES AS TO PUBLIC CHILD WELFARE

§ 701. Availability of services

1. In general

Even though board of arbitration of claims may have had jurisdiction to entertain cause of action asserted by private corporation against department of public welfare with regard to contract to develop and maintain child welfare service program where such contract lacked properly legislated and sufficient appropriation, board was powerless to make award to corporation based on such contract in that contract was unenforceable. Com., Dept. of Public Welfare v. Harambee, Inc., 346 A.2d 594, Cmwlth.1975.

Funds specifically appropriated for disbursement by department of public welfare directly to counties for use in child welfare field could not support contractual duty assumed by department of public welfare in favor of nongovernmental entity, whether or not consideration promised or provided by said nongovernmental entity would be identical to that intended through department-county interaction. Id.

Absent proof of county noncompliance with department of public welfare regulations, upon which department may avoid county participation and directly engage in affording child welfare services, sole method of effectuation of public child welfare programs is through county-department interaction whereby department acts as conduit for disbursement of funds to counties and as over-

seer of county operations through its regulatory power. Id.

Department of public welfare's agreement with nongovernmental agency to develop and maintain child welfare service program for benefit of commonwealth employees only, which was to be supported by funds specifically appropriated to department of public welfare for disbursement by department directly to counties, was both unenforceable and illegal. Id.

§ 703. Rules and regulations

1. Construction and application

Child welfare services was bound by regulations published by department of public welfare concerning treatment of children in emergency care. Janet D. v. Carros, 362 A.2d 1060, 240 Pa.Super. 291, 1976.

§ 704. Repealed. 1976, July 9, P.L. 846, No. 148, § 1, eff. Jan. 1, 1978

The repealed section, relating to annual grants, was derived Act 1929, April 9, P.L. 177, art. XXIII, § 2310.2(a) and (e), added 1963, Aug. 24, P.L. 1152, § 3, and from Act 1967, June 13, P.L. 31, No. 21, art. 7, § 704. Prior to repeal, the section was amended by Act 1972, Dec. 6, P.L. 1434, No. 316, § 1 and by Act 1976, July 9, P.L. 911, No. 165, § 1. See, now, § 704.1 of this title.

Retroactive Effect of 1976 Amendment: Section 2 of Act 1976, July 9, P.L. 911, No. 165 provides that the act shall take effect July 1, 1975 irrespective of the date of its final enactment.

§ 704.1 Payments to counties for services to children

This section will become effective January 1, 1978.

(a) The department shall reimburse county institution districts or their successors for expenditures incurred by them in the performance (P.L. 1464, No. 333), known as the "Juvenile Act," [1] in the following percentages:

(1) Eighty percent of the cost of an adoption subsidy paid pursuant to subdivision (e) of Article VII of this act.[2]

(2) No less than seventy-five percent and no more than ninety percent of the reasonable cost including staff costs of child welfare services, informal adjustment services provided pursuant to section 8 of the act of December 6, 1972 (P.L. 1464, No. 333), known as the "Juvenile Act." [3] and such services approved by the department, including but not limited to, foster home care, group home care, shelter care, community residential care, youth service bureaus, day treatment centers and service to children in their own home and any other alternative treatment programs approved by the department.

(3) Sixty percent of the reasonable administrative costs approved by the department except for those staff costs included in clause (2) of this section as necessary for the provision of child welfare services.

(4) Fifty percent of the actual cost of care and support of a child placed by a county child welfare agency or a child committed by a court pursuant to the act of December 6, 1972 (P.L. 1464, No. 333), known as the "Juvenile Act," to the legal custody of a public or private agency approved or operated by the department other than those services described in clause (2). The Auditor General shall ascertain the actual expense for fiscal year 1974–1975 and each year thereafter by the Department of Public Welfare for each of the several counties and each city of the first class whose children resident [4] within the county or city of the first class directly received the benefit of the Commonwealth's expenditure. The Auditor General shall also ascertain for each Commonwealth institution or facility rendering services to delinquent or deprived children the actual average daily cost of providing said services. The Auditor General shall certify to each county and city of the first class the allocated Commonwealth expenditures incurred on behalf of its children and notify the Secretary of Public Welfare and each county and city of the first class of same.

(5) Fifty percent of the reasonable cost of medical and other examinations and treatment of a child ordered by the court pursuant to the act of December 6, 1972 (P.L. 1464, No. 333), known as the "Juvenile Act," and the expenses of the appointment of a guardian pendente lite, summons, warrants, notices, subpoenas, travel expenses of witnesses, transportation of the child, and other like expenses incurred in proceedings un-

der the act of December 6, 1972 (P.L. 1464, No. 333), known as the "Juvenile Act."

(b) The department shall make additional grants to any county institution district or its successor to assist in establishing new services to children in accordance with a plan approved by the department for up to the first three years of operation of those services. In order to provide necessary information to the General Assembly relative to the grants provided under this subsection, a report will be developed by the Legislative Budget and Finance Committee and provided to the members of the General Assembly no later than July 1, 1980, concerning all grants made and expenditures accomplished under the provisions of this subsection for the period up to and including December 31, 1979. This report shall include information on the amount of moneys that went to individual counties and a description of activities and services financed with these moneys including the number and types of clients served under each of the grant programs and any other information necessary in order to fully inform the General Assembly on such programs. All officials of the Department of Public Welfare, grant recipient county organizations, and other agencies which receive State moneys under the provisions of this subsection shall cooperate with the committee and its staff in carrying out this reporting requirement, including making available all necessary fiscal and programmatic data.

(c) No payment pursuant to subsection (a)(2), (3) or (4) or of subsection (b) shall be made for any period in which the county institution district or its successor fails to substantially comply with the regulations of the department promulgated pursuant to section 703 including but not limited to those regulations relating to minimum child welfare services, minimum standards of child welfare services and minimum standards of child welfare administration on the merit basis.

(d) Amounts due from county institution districts or their successors for children committed to facilities operated by the department shall be paid by the counties to the Department of Revenue by orders to be drawn by the duly authorized agent of the Department of Revenue at each youth development center or forestry camp on the treasurers of such counties, who shall accept and pay the same to the Department of Revenue. Promptly after the last calendar day of each month the agent of the Department of Revenue shall mail accounts to the commissioners of such counties as may have become liable to the Commonwealth during the month under the provisions of this section. These accounts shall be duly sworn or affirmed to, and it shall be the duty of said commissioners, immediately upon receipt of such accounts, to notify the treasurers of their respective counties of the amounts of said accounts, with instructions to pay promptly to the Department of Revenue the amounts of said orders when presented. It shall then be the duty of such county treasurers to make such payments as instructed by their respective county commissioners. In lieu of payments by the county to the Commonwealth, the department may deduct the amount due the Commonwealth from the reimbursement payments by the department to the county institution districts or their successors.

(e) If, after due notice to the parents or other persons legally obligated to care for and support the child, and after affording them an opportunity to be heard, the court finds that they are financially able to pay all or part of the costs and expenses stated in subsection (a), the court may order them to pay the same and prescribe the manner of payment. Unless otherwise ordered, payment shall be made to the clerk of the court for remittance to the person to whom compensation is due, or if the costs and expenses have been paid by the county, to the appropriate officer of the county.

(f) The department shall prescribe the time at, and the form on which county institution districts or their successors shall submit to the de-

partment annual estimates of who will be served and the cost of such service under each category of service set forth in subsection (a).

(g) The department shall, within forty-five days of each calendar quarter, pay fifty percent of the department's share of the county institution district's or its successor's estimated expenditures for that quarter.

(h) At the end of each of calendar years 1978 and 1979, every county shall compare the amount received in child welfare reimbursements for calendar year 1976 pursuant to section 704 of this act [5] and section 36 of the act of December 6, 1972 (P.L. 1464, No. 333), known as the "Juvenile Act" [6] with child welfare reimbursements received for each of calendar years 1978 and 1979 pursuant to this section. The resulting difference in reimbursements for child welfare services received between calendar year 1976 and each of calendar years 1978 and 1979 shall then be compared with the amount the county paid in each of calendar years 1978 and 1979 for youth development center or forestry camp commitments pursuant to subsection (a)(4). If there is an increase in reimbursements for child welfare services and that increase is less in either or both of calendar years 1978 and 1979 than the amount expended by the county for its share of the cost of youth development center and forestry camp commitments, then any such county shall be entitled to receive additional block grants as provided in subsection (b) equal to the amount of such difference.

1967, June 13, P.L. 31, No. 21, § 704.1, added 1976, July 9, P.L. 846, No. 148, § 2, effective Jan. 1, 1978.

[1] 11 P.S. § 50-101 et seq.
[2] Section 701 et seq. of this title.
[3] 11 P.S. § 50-304.
[4] So in original.
[5] Section 704 of this title.
[6] 11 P.S. § 50-333.

1. Construction and application

The Department of Public Welfare is liable, pursuant to this section, for one-half of the actual costs of the placement and care of juveniles committed by a court, under the Juvenile Act (11 P.S. § 50—101 et seq.) to a drug or alcohol treatment facility approved by the department. 1977 Op.Atty.Gen. No. 17.

A drug or alcohol treatment facility may be a "public or private agency approved by the Department" if that facility has received the approval of the department issued pursuant to this section. Id.

§ 704.2 Contingent liability of state and local government; intention of act

This section will become effective January 1, 1978.

(a) Neither the State nor a county institution district or its successor shall be required to expend public funds for services described in section 704.1 [1] on behalf of a child until such child has exhausted his eligibility and receipt of benefits under all other existing or future private, public, local, State or Federal programs other than programs funded by the act of October 20, 1966 (3rd Sp.Sess., P.L. 96, No. 6), known as the "Mental Health and Mental Retardation Act of 1966." [2]

(b) Upon exhaustion of such eligibility as aforesaid, the Commonwealth and the county institution districts or their successors shall share the financial obligation accruing under section 704.1 to the extent such obligations are not borne by the Federal Government or any private person or agency.

(c) It is the intention of this section that its provisions be construed so as to maintain and not decrease or destroy any eligibility of any person, any facility of the State or any political subdivision to receive any Federal assistance, grants or funds.

1967, June 13, P.L. 31, No. 21, § 704.2, added 1976, July 9, P.L. 846, No. 148, § 2, effective Jan. 1, 1978.

[1] Section 704.1 of this title.
[2] 50 P.S. § 4101 et seq.

§ 705. Repealed. 1976, July 9, P.L. 846, No. 148, § 1, eff. Jan. 1, 1978

The repealed section, relating to annual plans and computation of grants, was derived from Act 1929, April 9, P.L. 177, art. XXIII, § 2310.2(b) and (c), added 1963, Aug. 24, P.L. 1152, § 3 and 1967, June 13, P.L. 31, No. 21, art. 7, § 705. See, now, § 704.1 of this title.

§ 706. Repealed. 1976, July 9, P.L. 846, No. 148, § 3, eff. Jan. 1, 1978

The repealed section, relating to payment of annual grants, was derived from Act 1929, April 9, P.L. 177, art. XXIII, § 2310.2(d), added 1963, Aug. 24, P.L. 1152, § 3, and Act 1967, June 13, P.L. 31, No. 21, art. 7, § 706. See, now, § 704.1 of this title.

§ 707. Repealed. 1976, July 9, P.L. 846, No. 148, § 3, eff. Jan. 1, 1978

The repealed section, relating to adjustment of annual grants, was derived from Act 1929, April 9, P.L. 177, art. XXIII, § 2310.3, added 1963, Aug. 24, P.L. 1152, § 3, and from 1967, June 13, P.L. 31, No. 21, art. 7, § 707. See, now, § 704.1 of this title.

§ 708. Departmental administration of county child welfare services

Text of section effective January 1, 1978.

On and after January 1, 1968, the department shall provide, maintain, administer, manage and operate a program of child welfare services in a county institution district or its successor when the department determines, after hearing, that such county institution district or its successor is not complying with the regulations prescribing minimum child welfare services or minimum standards of performance of child welfare services or minimum standards of child welfare personnel administration on a merit basis, and that, as a result, the needs of children and youth are not being adequately served.

When, in pursuance of this section, the department takes charge of, and directs the operation of the child welfare services of a county institution district or its successor, the county shall be charged and shall pay the cost of such services, including reasonable expenditures incident to the administration thereof incurred by the department. The amount so charged and to be paid by the county shall be reduced by the amount of the payments that would have been made pursuant to section 704.1 [65] if the county institution district or its successor had maintained a child welfare program in compliance with the regulations of the department.

The amount due the Commonwealth may be deducted from any Commonwealth funds otherwise payable to the county. All sums collected from the county under this section, in whatever manner such collections are made, shall be paid into the State treasury and shall be credited to the current appropriation to the department for child welfare.

The department shall relinquish the administration of the child welfare program of the county institution district or its successor when the department is assured that the regulations of the department will be complied with thereafter and that the needs of children and youth will be adequately served.

As amended 1976, July 9, P.L. 846, No. 148, § 4, effective Jan. 1, 1978.

For text of section effective until January 1, 1978, see main volume.

1. In general

Even though board of arbitration of claims may have had jurisdiction to entertain cause of action asserted by private corporation against department of public welfare with regard to contract to develop and maintain child welfare service program where such contract lacked properly legislated and sufficient appropriation, board was powerless to make award to corporation based on such contract in that contract was unenforceable. Com., Dept. of Public Welfare v. Harambee, Inc., 346 A.2d 594, Cmwlth.1975.

Department of public welfare's agreement with nongovernmental agency to develop and maintain child welfare service program for benefit of commonwealth employees only, which was to be supported by funds specifically appropriated to department of public welfare for disbursement by department directly to counties, was both unenforceable and illegal. Id.

Funds specifically appropriated for disbursement by department of public welfare directly to counties for use in child welfare field could not support contractual duty assumed by department of public welfare in favor of nongovernmental entity, whether or not consideration promised or provided by said nongovernmental entity would be identical to that intended through department-county interaction. Id.

Absent proof of county noncompliance with department of public welfare regulations, upon which department may avoid county participation and directly engage in affording child welfare services, sole method of effectuation of public child welfare programs is through county-department interaction whereby department acts as conduit for disbursement of funds to counties and as overseer of county operations through its regulatory power. Id.

(b) DEPARTMENTAL POWERS AND DUTIES AS TO DELINQUENCY

§ 725. Study of delinquents; recommendations to courts

Cross References
Juvenile Act, see 11 P.S. § 50—101 et seq.

(c) INTERSTATE COMPACT ON JUVENILES

§ 731. Authorization; compact provisions

(a) The Governor is hereby authorized and directed to execute a compact on behalf of the Commonwealth of Pennsylvania with any other state or states legally joining therein in form substantially as follows: As amended 1973, July 25, P.L. 201, No. 49, § 1, imd. effective.

INTERSTATE COMPACT ON JUVENILES

The contracting states solemnly agree:

[*See main volume for text of Article I to Article XVI*]

(b) The Governor is authorized and directed to execute, with any other state or states legally joining in the same, an amendment to the Interstate Compact on Juveniles in form substantially as follows:

ARTICLE XVII. AMENDMENT TO THE INTERSTATE COMPACT ON JUVENILES, INTERSTATE RENDITION OF JUVENILES ALLEGED TO BE DELINQUENT

(a) This amendment shall provide additional remedies, and shall be binding only as among and between those party states which specifically execute the same.

(b) All provisions and procedures of Articles V and VI of the Interstate Compact on Juveniles shall be construed to apply to any juvenile charged with being a delinquent by reason of a violation of any criminal law. Any juvenile, charged with being a delinquent by reason of violating any criminal law shall be returned to the requesting state upon a requisition to the state where the juvenile may be found. A petition in such case shall be filed in a court of competent jurisdiction in the requesting state where the violation of criminal law is alleged to have been committed. The petition may be filed regardless of whether the juvenile has left the state before or after the filing of the petition. The requisition described in Article V of the compact shall be forwarded by the judge of the court in which the petition has been filed.

Added 1973, July 25, No. 49, § 2, imd. effective.

Complementary Laws:
Alabama—Code of Ala.1975, §§ 44-2-1 to 44-2-7.
Colorado—C.R.S. 73, 24-60-701 to 24-60-708.
D.C.—D.C.C.E. §§ 32-1101 to 32-1106.
Fla.—West's F.S.A. §§ 39.25 to 39.31.
Georgia—Code §§ 99-3401 to 99-3407.
Hawaii—HRS §§ 582-1 to 582-8.
Idaho—I.C. §§ 16-1901 to 16-1910.
Indiana—I.C.1971, 31-5-3-1 to 31-5-3-9.
Iowa—I.C.A. §§ 231.14, 231.15.
Kan.—K.S.A. 38-1001 et seq.
Ky.—K.R.S. 208.600, 208.660, 208.670.
Md.—Code 1957, art. 41, §§ 387 to 395.
Miss.—Code 1972, §§ 43-25-1 to 43-25-17.
Montana—R.C.M.1947, §§ 10-1001 to 10-1006.
Nebraska—R.R.S.1943, §§ 43-1001 to 43-1009.
Nevada—N.R.S. 214.010 to 214.060.
New Hampshire—R.S. 169-A:1 to 169-A:9.
New Mexico—1953 Comp. §§ 13-16-1 to 13-16-8.
North Dakota—NDCC 27-22-01 to 27-22-06.
Oregon—ORS 417.010 to 417.080.
Rhode Island—Gen.Laws 1956, §§ 14-6-1 to 14-6-11.
South Carolina—Code 1962, § 55-65.
South Dakota—SDCL 26-12-1 to 26-12-13.
Texas—V.T.C.A., Family Code §§ 25.01 to 25.09.
Vermont—33 V.S.A. § 551 et seq.
Virginia—Code 1950, §§ 16.1-323 to 16.-1-330
West Virginia—Code, 49-8-1 to 49-8-7.
Wyoming—W.S.1957, § 14-52.10.

Cross References
Juvenile Act, see 11 P.S. § 50—101 et seq.

1. Construction and application
Since New Jersey has not adopted amendment to interstate compact on juveniles providing that compact applies to any juvenile charged with being a delinquent by reason of violation of any criminal law New Jersey properly re-

quested return of 17-year old, who was sought on murder charges, under the Uniform Criminal Extradition Act, 19 P.S. § 191.1 et seq., and, hence, court of common pleas had jurisdiction to order juvenile extradited; proceedings were not required to be transferred to Juvenile Court. Com. ex rel. Reyes v. Aytch, 369 A.2d 1325, 246 Pa.Super. 287, 1976.

Although being a fugitive constitutes a delinquent act under Pennsylvania law, such fact did not require transfer of extradition proceeding involving 17-year-old from court of common pleas to juvenile court since Pennsylvania never sought to obtain jurisdiction for any purpose other than to return the subject to South Carolina. Com. ex rel. Colbert v. Aytch, 369 A.2d 1321, 246 Pa.Super. 278, 1977.

The interstate compact on juveniles is based on reciprocity, and responding jurisdiction cannot honor request based upon provision contained in version of compact adopted by initiative jurisdiction, but not contained in version of compact adopted by initiative jurisdiction, but not contained in version adopted by responding jurisdiction. In re Adams, 121 P.L.J. 228, 1972.

Intent on interstate compact on juveniles is remedial in nature rather than punitive and the basic consideration is the interest and welfare of the juvenile. Id.

§ 731.1 Out-of-State Confinement

The Out-of-State Confinement Amendment to the Interstate Compact on Juveniles is hereby enacted into law and entered into by this State with all other states legally joining therein in the form substantially as follows:

OUT-OF-STATE CONFINEMENT AMENDMENT

(a) Whenever the duly constituted judicial or administrative authorities in a sending state shall determine that confinement of a probationer or reconfinement of a parolee is necessary or desirable, said officials may direct that the confinement or reconfinement be in an appropriate institution for delinquent juveniles within the territory of the receiving state, such receiving state to act in that regard solely as agent for the sending state.

(b) Escapees and absconders who would otherwise be returned pursuant to Article V of the Compact may be confined or reconfined in the receiving state pursuant to this amendment. In any such case the information and allegations required to be made and furnished in a requisition pursuant to such article shall be made and furnished, but in place of the demand pursuant to Article V, the sending state shall request confinement or reconfinement in the receiving state. Whenever applicable, detention orders as provided in Article V may be employed pursuant to this paragraph preliminary to disposition of the escapee or absconder.

(c) The confinement or reconfinement of a parolee, probationer, escapee, or absconder pursuant to this amendment shall require the concurrence of the appropriate judicial or administrative authorities of the receiving state.

(d) As used in this amendment: (1) "sending state" means sending state as that term is used in Article VIII of the Compact or the state from which a delinquent juvenile has escaped or absconded within the meaning of Article V of the Compact; (2) "receiving state" means any state, other than the sending state, in which a parolee, probationer, escapee, or absconder may be found, provided that said state is a party to this amendment.

(e) Every state which adopts this amendment shall designate at least one of its institutions for delinquent juveniles as a "Compact Institution" and shall confine persons therein as provided in paragraph (a) hereof unless the sending and receiving state in question shall make specific contractual arrangements to the contrary. All states party to this amendment shall have access to "Compact Institutions" at all reasonable hours for the purpose of inspecting the facilities thereof and for the purpose of visiting such of said state's delinquents as may be confined in the institution.

(f) Persons confined in "Compact Institutions" pursuant to the terms of this compact shall at all times be subject to the jurisdiction of the sending state and may at any time be removed from said "Compact Institution" for transfer to an appropriate institution within the sending state,

for return to probation or parole, for discharge, or for any purpose permitted by the laws of the sending state.

(g) All persons who may be confined in a "Compact Institution" pursuant to the provisions of this amendment shall be treated in a reasonable and humane manner. The fact of confinement or reconfinement in a receiving state shall not deprive any person so confined or reconfined of any rights which said person would have had if confined or reconfined in an appropriate institution of the sending state; nor shall any agreement to submit to confinement or reconfinement pursuant to the terms of this amendment be construed as a waiver of any rights which the delinquent would have had if he had been confined or reconfined in any appropriate institution of the sending state except that the hearing or hearings, if any, to which a paroiee, probationer, escapee, or absconder may be entitled (prior to confinement or reconfinement) by the laws of the sending state may be had before the appropriate judicial or administrative officers of the receiving state. In this event, said judicial and administrative officers shall act as agents of the sending state after consultation with appropriate officers of the sending state.

(h) Any receiving state incurring costs or other expenses under this amendment shall be reimbursed in the amount of such costs or other expenses by the sending state unless the states concerned shall specifically otherwise agree. Any two or more states party to this amendment may enter into supplementary agreements determining a different allocation of costs among themselves.

(i) This amendment shall take initial effect when entered into by any two or more states party to the compact and shall be effective as to those states which have specifically enacted this amendment. Rules and regulations necessary to effectuate the terms of this amendment may be promulgated by the appropriate officers of those states which have enacted this amendment.

Added 1973, July 25, P.L. 202, No. 49, § 3, imd. effective.

(d) INTERSTATE PLACEMENT OF CHILDREN

§§ 741 to 745. Repealed. 1973, July 27, P.L. 231, No. 61, § 2, imd. effective.

§ 746. Definitions [In general]

As used in this act:

"Child" means any individual who has not yet passed his eighteenth birthday and includes one conceived but not yet born.

"Department" means the Department of Public Welfare of this Commonwealth.

"Person" means an individual, agency, association, corporation or institution.

"Placement" means either effecting admission of a child to an institution, except an educational institution, or effecting his reception in a family home, whether or not a charge is made for his care by the institution or family home.

Added 1973, July 27, P.L. 231, No. 61, § 3, imd. effective.

§ 747. Consent required for bringing child into State

(a) Without first obtaining the consent of the department, no person shall bring or send any child or cause him to be brought or sent into this Commonwealth with the purpose of placement or of procuring the child's adoption.

(b) Subsection (a) of this section shall not apply if the child is received into this Commonwealth by an institution or agency supervised by the department and notice of the child's placement is furnished the department within seven days.

Added 1973, July 27, P.L. 231, No. 61, § 3, imd. effective.

§ 748. Department's consent to placement

Before issuing its consent to a child's placement in this Commonwealth as required in section 747, the department shall:

(1) Satisfy itself that the proposed placement and all arrangements therefor, are suitable for the nature of the child and are in conformity with applicable regulations of the department;

(2) Receive from the person accepting the child for placement or adoption written agreement to conform to all applicable regulations of the department and, at least semi-annually, and at such other times as the department may require, to report as to the location and well-being of the child until he reaches his eighteenth birthday or is adopted.

Added 1973, July 27, P.L. 231, No. 61, § 3, imd. effective.

§ 749. Bond required; forfeiture and assignment

At its discretion, the department may require of the person bringing or sending a child into this Commonwealth for placement or adoption or of the person who receives such child, an indemnity bond in favor of the Commonwealth of Pennsylvania in the penal sum of one thousand dollars ($1,000) conditioned as follows: That the child is not of unsound mind or body and that, if prior to his eighteenth birthday or his adoption, he becomes a public charge or is adjudged a delinquent, he will be removed from the State on demand of the department.

Any person, subject to this act, having had thirty days' notice and demand by the department to remove from the State any child admitted under the provisions of this act shall, upon failure to remove the child, forfeit the sum of one thousand dollars ($1,000) as a penalty therefor to be recovered upon such bond by a suit in the name of the Commonwealth of Pennsylvania. This sum, or any part thereof, collected by the Commonwealth may be assigned by the department to a supervised child caring agency designated by the department to replace the child.

Added 1973, July 27, P.L. 231, No. 61, § 3, imd. effective.

§ 750. Notice of movement of child from this Commonwealth

No person shall take any child, send or cause him to be taken or sent to another state for the purpose of placement or of procuring his adoption without providing information to the department about the child and his placement. The department shall immediately send such information to the appropriate department of government of the receiving state.

Added 1973, July 27, P.L. 231, No. 61, § 3, imd. effective.

§ 751. Regulations

The department may make such regulations for the administration of this act as it deems necessary.

Added 1973, July 27, P.L. 231, No. 61, § 3, imd. effective.

§ 752. Application

The provisions of this act shall not apply to a parent, stepparent, grandparent, aunt or uncle, nor to an adult brother, sister, half brother or half sister, when any such relative receives or brings a child into this Commonwealth for the purpose of giving him a home in the relative's own family.

If Pennsylvania becomes a party to the Interstate Compact on Children, this act shall not apply to public or voluntary agencies in other party states.

Added 1973, July 27, P.L. 231, No. 61, § 3, imd. effective.

§ 753. Penalty

Any person who knowingly violates any provision of this act is guilty of a misdemeanor and, upon conviction thereof, shall be sentenced to pay a fine of not more than one hundred dollars ($100) or to undergo imprisonment for not more than thirty days or both.

Added 1973, July 27, P.L. 231, No. 61, § 3, imd. effective.

§ 761. Authorization; compact provisions

The Governor is hereby authorized and directed to execute a compact on behalf of the Commonwealth of Pennsylvania with any other state or states legally joining therein in form substantially as follows:

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

ARTICLE I

PURPOSE AND POLICY

It is the purpose and policy of the party states to cooperate with each other in the interstate placement of children to the end that:

(a) Each child requiring placement shall receive the maximum opportunity to be placed in a suitable environment and with persons or institutions having appropriate qualifications and facilities to provide a necessary and desirable degree and type of care.

(b) The appropriate authorities in a state where a child is to be placed may have full opportunity to ascertain the circumstances of the proposed placement, thereby promoting full compliance with applicable requirements for the protection of the child.

(c) The proper authorities of the State from which the placement is made may obtain the most complete information on the basis of which to evaluate a projected placement before it is made.

(d) Appropriate jurisdictional arrangements for the care of children will be promoted.

ARTICLE II

DEFINITIONS

As used in this compact:

(a) "Child" means a person who, by reason of minority, is legally subject to parental guardianship or similar control.

(b) "Sending agency" means a party state, officer or employe thereof, a subdivision of a party state or officer or employe thereof, a court of a party state, a person, corporation, association, charitable agency or other entity which sends, brings or causes to be sent or brought, any child to another party state.

(c) "Receiving state" means the state to which a child is sent, brought or caused to be sent or brought, whether by public authorities or private persons or agencies and whether for placement with state or local public authorities or for placement with private agencies or persons.

(d) "Placement" means the arrangement for the care of a child in a family, free or boarding home, or in a child-caring agency or institution but does not include any institution caring for the mentally ill, mentally defective or epileptic or any institution primarily educational in character and any hospital or other medical facility.

ARTICLE III

CONDITIONS FOR PLACEMENT

(a) No sending agency shall send, bring or cause to be sent or brought into any other party state, any child for placement in foster care or as a preliminary to a possible adoption unless the sending agency shall comply with each and every requirement set forth in this article and with the applicable laws of the receiving state governing the placement of children therein.

(b) Prior to sending, bringing or causing any child to be sent or brought into a receiving state for placement in foster care or as a preliminary to a possible adoption, the sending agency shall furnish the appropriate public authorities in the receiving state written notice of the intention to send, bring or place the child in the receiving state. The notice shall contain:

(1) The name, date and place of birth of the child.

(2) The identity and address or addresses of the parents or legal guardian.

(3) The name and address of the person, agency or institution to, or with which, the sending agency proposes to send, bring or place the child.

(4) A full statement of the reasons for such proposed action and evidence of the authority pursuant to which the placement is proposed to be made.

(c) Any public officer or agency in a receiving state, which is in receipt of a notice pursuant to paragraph (b) of this article, may request of the sending agency or any other appropriate officer or agency of, or in the sending agency's state, and shall be entitled to receive therefrom such supporting or additional information as it may deem necessary under the circumstances to carry out the purpose and policy of this compact

(d) The child shall not be sent, brought or caused to be sent or brought into the receiving state until the appropriate public authorities in the receiving state shall notify the sending agency, in writing, to the effect that the proposed placement does not appear to be contrary to the interests of the child.

ARTICLE IV

PENALTY FOR ILLEGAL PLACEMENT

The sending, bringing or causing to be sent or brought into any receiving state, of a child, in violation of the terms of this compact, shall constitute a violation of the laws respecting the placement of children of both the state in which the sending agency is located or from which it sends or brings the child and of the receiving state. Such violation may be punished or subjected to penalty in either jurisdiction in accordance with its laws. In addition to liability for any such punishment or penalty, any such violation shall constitute full and sufficient grounds for the suspension or revocation of any license, permit or other legal authorization held by the sending agency which empowers or allows it to place or care for children.

ARTICLE V

RETENTION OF JURISDICTION

(a) The sending agency shall retain jurisdiction over the child sufficient to determine all matters in relation to the custody, supervision, care, treatment and disposition of the child which it would have had if the child had remained in the sending agency's state until the child is adopted, reaches majority, becomes self-supporting, or is discharged with the concurrence of the appropriate authority in the receiving state. Such jurisdiction shall also include the power to effect or cause the return of the child or its transfer to another location and custody pursuant to law. The sending agency shall continue to have financial responsibility for support and maintenance of the child during the period of the placement. Nothing contained herein shall defeat a claim of jurisdiction by a receiving state sufficient to deal with an act of delinquency or crime committed therein.

(b) When the sending agency is a public agency, it may enter into an agreement with an authorized public or private agency in the receiving

state providing for the performance of one or more services in respect of such case by the latter, as agent for the sending agency.

(c) Nothing in this compact shall be construed to prevent a private, charitable agency, authorized to place children in the receiving state, from performing services or acting as agent in that state for a private charitable agency of the sending state nor to prevent the agency in the receiving state from discharging financial responsibility for the support and maintenance of a child who has been placed, on behalf of the sending agency, without relieving the responsibility set forth in paragraph (a) hereof.

ARTICLE VI

INSTITUTIONAL CARE OF DELINQUENT CHILDREN

A child adjudicated delinquent may be placed in an institution in another party jurisdiction, pursuant to this compact, but no such placement shall be made unless the child is given a court hearing, on notice to the parent or guardian, with opportunity to be heard prior to his being sent to such other party jurisdiction for institutional care and the court finds that:

(1) Equivalent facilities for the child are not available in the sending agency's jurisdiction, and

(2) Institutional care in the other jurisdiction is in the best interest of the child and will not produce undue hardship.

ARTICLE VII

COMPACT ADMINISTRATOR

The executive head of each jurisdiction party to this compact shall designate an officer who shall be general coordinator of activities under this compact in his jurisdiction and who, acting jointly with like officers of other party jurisdictions, shall have power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact.

ARTICLE VIII

LIMITATIONS

This compact shall not apply to:

(a) The sending or bringing of a child into a receiving state by his parent, stepparent, grandparent, adult brother or sister, adult uncle or aunt, or his guardian and leaving the child with any such relative or nonagency guardian in the receiving state.

(b) Any placement, sending or bringing of a child into a receiving state, pursuant to any other interstate compact to which both the state from which the child is sent or brought and the receiving state, are party or to any other agreement between said states which has the force of law.

ARTICLE IX

ENACTMENT AND WITHDRAWAL

This compact shall be open to joinder by any state, territory or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico and, with the consent of Congress, the Government of Canada or any province thereof. It shall become effective with respect to any such jurisdiction when such jurisdiction has enacted the same into law. Withdrawal from this compact shall be by the enactment of a statute repealing the same but shall not take effect until two years after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the Governor of each other party jurisdiction. Withdrawal of a party state shall not affect the rights, duties and obligations under this compact of any sending agency therein with respect to a placement made prior to the effective date of withdrawal.

ARTICLE X

CONSTRUCTION AND SEVERABILITY

The provisions of this compact shall be liberally construed to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

Added 1973, July 25, P.L. 205, No. 50, § 2, imd. effective.

Complementary Laws:

Alaska—AS 47.70.010 to 47.70.080
Ariz.—A.R.S. §§ 8-548 to 8-548.06.
Cal.—West's Ann.Civ.Code, § 264 to 274.
Colo.—C.R.S. '73, 24-60-1801 to 24-60-1803.
Conn.—C.G.S.A. § 17-81a.
Del.—31 Del.C.Ann. § 381.
Fla.—West's F.S.A. §§ 409.401 to 409.405.
Idaho—I.C. §§ 16-2101 to 16-2107.
Ill.—S.H.A. ch. 23, §§ 2601 to 2609.
Iowa—I.C.A. § 238.33.
Kan.—K.S.A. 38-1201 to 38-1206.
Ky.—KRS 199.341 to 199.347.
La.—LSA-R.S. 46:1700 to 46:1706.
Me.—22 M.R.S.A. §§ 4191 to 4200.
Md.—Code 1957, §§ 16-208 to 16-212F.
Mass.—M.G.L.A. c. 119 App. §§ 2-1 to 2-8.
Minn.—M.S.A. §§ 257.40 to 257.48.
Miss.—Code 1972, §§ 43-18-1 to 43-18-17.
Mo.—V.A.M.S. §§ 210.620 to 210.640.
Mont.—R.C.M.1947, §§ 10-1401 to 10-1409.
Neb.—R.S.S.1943, 43-1101.
N.H.—RSA 170-A:1 to 170-A:6.
N.Y.—McK. Social Services Law, § 374a.
N.C.—G.S. §§ 110-57.1 to 110-57.7.
N.D.—NDCC 14-13-01 to 14-13-08.
Ohio—R.C. §§ 5103.20 to 5103.28.
Okl.—10 Okl.St.Ann. §§ 571 to 576.
Ore.—ORS 417.200 to 417.290.
Pa.—62 P.S. §§ 761 to 765.
R.I.—Gen.Laws 1956, §§ 40-22-1 to 40-22-10.
S.D.—SDCL 26-13-1 to 26-13-9.
Tenn.—T.C.A. §§ 37-1401 to 37-1409.
Tex.—Vernon's Ann.Civ.St. art. 695a—2.
Utah—U.C.A.1953, 55-8b-1 to 55-8b-8.
Vt.—33 V.S.A. §§ 3151 to 3160.
Va.—Code 1950, §§ 63.1-219.1 to 63.1-219.6.
Wash.—R.C.W.A. 26.34.010 to 26.34.080.
W.Va.—Code, 49-2A-1, 49-2A-2.
Wyo.—W.S.1957, §§ 14-52.1 to 14-52.9.

§ 762. Financial responsibility

Financial responsibility for any child placed, pursuant to the provisions of the Interstate Compact on the Placement of Children, shall be determined in accordance with the provisions of Article V thereof in the first instance. However, in the event of partial or complete default of performance thereunder, the provisions of any laws of the Commonwealth fixing responsibility for the support of children also may be invoked.

Added 1973, July 25, P.L. 205, No. 50, § 2, imd. effective.

§ 763. Definitions [Compact]

(1) As used in paragraph (a) of Article V of the Interstate Compact on the Placement of Children, the phrase "appropriate authority in the receiving state," with reference to this State, shall mean the Department of Public Welfare;

(2) As used in Article III of the Interstate Compact on the Placement of Children, the "appropriate public authorities" shall, with reference to this State, mean the Department of Public Welfare and said department shall receive and act with reference to notices required by said Article III;

(3) As used in Article VII of the Interstate Compact on the Placement of Children, the term "executive head" means the Governor of the Commonwealth of Pennsylvania. The Governor is hereby authorized to designate an officer who shall be the compact administrator in accordance with the terms of said Article VII.

Added 1973, July 25, P.L. 205, No. 50, § 2, imd. effective.

§ 764. Agreements

The officers and agencies of this State and its subdivisions, having authority to place children, are hereby empowered to enter into agreements with appropriate officers or agencies of, or in, other party states pursuant to paragraph (b) of Article V of the Interstate Compact on the Placement of Children. Any such agreement which contains a financial commitment or imposes a financial obligation on this State, or subdivision, or agency thereof, shall not be binding unless it has the approval in writing, of the Secretary of Public Welfare in the case of the State or any agency thereof and of the local public welfare administrative authority in the case of a subdivision of the State.

Added 1973, July 25, P.L. 205, No. 50, § 2, imd. effective.

§ 765. Courts; jurisdiction

Any court having jurisdiction to place delinquent children may place such a child in an institution of or in another state pursuant to Article VI of the Interstate Compact on the Placement of Children and shall retain jurisdiction as provided in Article V thereof.

Added 1973, July 25, P.L. 205, No. 50, § 2, imd. effective.

(e) ADOPTION OPPORTUNITIES ACT [NEW]

§ 771. Declaration of purpose

This subdivision shall be interpreted and construed so as to effect the following purpose: to encourage and promote the placement in adoptive homes of children who are physically and/or mentally handicapped, emotionally disturbed, or hard to place by virtue of age, sibling relationship, or ethnicity.

1967, June 13, P.L. 31, No. 21, art. 7, § 771, added 1974, Dec. 30, P.L. 1039, No. 339, § 1, imd. effective.

Effective Date:
Section 2 of Act 1974, Dec. 30, P.L. 1039, No. 339 provided that: "This act shall take effect immediately so as to permit the Department of Public Welfare to establish regulations, but no payments shall be made prior to July 1, 1975."

Library References
Infants ⇐17.
C.J.S. Infants §§ 17, 18.

§ 772. Definitions

As used in this subdivision:

"Adoption opportunity" is a subsidy which may include maintenance cost; medical, surgical, and psychological expenses; and other costs incident to the adoption.

"Child" means an individual who is under the age of eighteen years.

"Eligible child" means a child in the legal custody of local authorities where parental rights have been terminated pursuant to the procedure set forth in Article III of the act of July 24, 1970 (P.L. 620, No. 208), known as the "Adoption Act," [1] and such child has been in foster placement for a period of not less than six months and where the child has been shown to be a difficult adoption placement because of a physical and/or mental handicap, emotional disturbance, or by virtue of age, sibling relationship, or ethnicity. A child in the legal custody of an agency approved by the department shall be an eligible child if the child is certified as eligible by the local authorities.

"Local authorities" means county institution districts or their successors.

1967, June 13, P.L. 31, No. 21, art. 7, § 772, added 1974, Dec. 30, P.L. 1039, No. 339, § 1, imd. effective.

[1] 1 P.S. § 301 et seq.

§ 773. Rules and regulations

(a) The Department of Public Welfare shall establish and develop criteria and promulgate necessary regulations for public child welfare agencies to implement an adoption opportunity in accordance with the provisions of this subdivision (e).

(b) The regulations shall include, but not be limited to, criteria for identifying eligible children and adoptive homes, procedures for implementing the subsidy, and reporting requirements by local authorities.

(c) All regulations established pursuant to this section shall be adopted pursuant to the act of July 31, 1968 (P.L. 769, No. 240), known as the "Commonwealth Documents Law," [1] and the hearings referred to in section 202 of that act [2] shall be mandatory.

1967, June 13, P.L. 31, No. 21, art. 7, § 773, added 1974, Dec. 30, P.L. 1039, No. 339, § 1, imd. effective.

[1] 45 P.S. § 1101 et seq.
[2] 45 P.S. § 1202.

§ 774. Adoption opportunity payments and reimbursement

(a) The amount of adoption subsidy for maintenance costs to an adoptive family shall not exceed the monthly payment rate for foster family care in the county in which the child resides.

(b) The department shall reimburse local authorities for at least eighty percent (80%) of the cost of an adoption opportunity provided by local authority pursuant to the provisions of this subdivision (e), provided the local authority complies with the reporting requirements established by the department pursuant to section 773.

(c) No public funds shall be expended under this subdivision (e) on behalf of an eligible child until all available benefits under existing or future private, public, local, State, or Federal programs have been exhausted. Notwithstanding any other provision of law, adoptive families subsidized under the provisions of this subdivision (e) shall not be liable pursuant to the provisions of the act of October 20, 1966 (3rd Sp.Sess., P.L. 96, No. 6), known as the "Mental Health and Mental Retardation Act of 1966," [1] or the act of June 24, 1937 (P.L. 2045, No. 397), known as "The Support Law," [2] in the event that the adopted child needs services or assistance under the provisions of Article IV of this act or under the provisions of the "Mental Health and Mental Retardation Act of 1966."

1967, June 13, P.L. 31, No. 21, art. 7, § 774, added 1974, Dec. 30, P.L. 1039, No. 339, § 1, imd. effective.

[1] 50 P.S. § 4101 et seq.
[2] Section 1971 et seq. of this title.

See note relative to 1974 Act under section 771 of this title.

ARTICLE VIII. THE BLIND AND VISUALLY HANDICAPPED

§ 801. Departmental powers and duties

1. In general

State Council for Blind may legally make payments to sectarian institutions under provisions of former 71 P.S. § 610 (now this section et seq.) for medical treatment of blind persons and for tuition for blind and visually handicapped persons, and such payments would not offend Const. Art. 3, § 18 (now § 29), since they do not represent appropriations for charitable, educational or benevolent purposes. 1958 Op.Atty.Gen. No. 132.

ARTICLE IX. DEPARTMENTAL POWERS AND DUTIES AS TO SUPERVISION

Reorganization Plan No. 3 of 1975

For provisions of Reorganization Plan No. 3 of 1975 relating to transfer of nursing home functions, powers and duties from Department of Public Welfare to Department of Health, see 71 P.S. § 756–3.

Suspended in Part

This article is suspended insofar as it is in conflict with the provisions of Reorganization Plan No. 3 of 1975. See section 7 of 71 P.S. § 756–3.

Reorganization Plan No. 2 of 1977

For provisions of Reorganization Plan No. 2 of 1977 relating to transfer from Department of Public Welfare to Governor's Council on Drug and Alcohol Abuse of functions, powers and duties relating to the regulation, supervision and licensing of drug and alcohol facilities, see 71 P.S. § 757-2.

Suspended in Part

This article is suspended insofar as it is in conflict with the provisions of Reorganization Plan No. 2 of 1977. See 71 P.S. § 757-2.

§ 901. Definitions

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

1. **Construction and application**

Philadelphia would not be required to receive approval from state before such city could close hospital which was maintained by city and which received state aid. Preston v. City of Philadelphia, 362 A.2d 452, 26 Pa.Cmwlth. 106, 1976.

Girard College is a children's institution, and subject to supervision and visitation by department of public welfare. 1961 Op.Atty.Gen. No. 239.

§ 902. Supervisory powers

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

Clause (6) of this section is suspended insofar as it is in conflict with Reorganization Plan No. 5 of 1973. See 71 P.S. § 755-5.

1. **Construction and application**

The administration of the provider agreement issuance function was not transferred to the Department of Health by Reorganization Plan No. 3 (71 P.S. § 756-3), and it continues to be the responsibility of the Department of Public Welfare. Since the Reorganization Plan explicitly limited transfer of nursing home related functions by excepting "those powers necessary for the Department of Public Welfare to retain its status as the Single State Agency in compliance with the Social Security Act" and since the Department of Health, Education and Welfare has now ruled that the transfer of issuance of nursing home provider agreements would jeopardize that status, the transfer of that function has never occurred as a matter of law. Official Opinion No. 76-18 is hereby overruled. 1976 Op.Atty.Gen. No. 32.

Long-term foster placement may not be terminated without affording opportunity to foster parents and child of hearing at which they may challenge accuracy or sufficiency of reasons given for termination and at which interests of child in family relationship can be examined and determined. 1974 Op.Atty. Gen.No. 32.

Girard College is a children's institution, and subject to supervision and visitation by department of public welfare. 1961 Op.Atty.Gen. No. 239.

§ 911. Visitation and inspection

(a) The department shall have the power, and its duty shall be:

(1) To make and enforce rules and regulations for a visitation, examination and inspection of all supervised institutions and said visitation, examination or inspection may occur both before and after the beginning of operation of the supervised facility.

(2) To visit and inspect, at least once in each year, all state and supervised institutions; to inquire and examine into their methods of instruction, discipline, detention, care or treatment, the care, treatment, govern-

ment or management of their inmates or those committed thereto, or being detained, treated or residing therein, the official conduct of their inspectors, trustees, managers, directors or other officer or officers charged with their management by law or otherwise, or having the management, care, custody or control thereof, the buildings, grounds, premises, and equipment thereof, or connected therewith, and all and every matter and thing relating to their usefulness, administration, and management, and to the welfare of the inmates thereof, or those committed thereto or being detained, treated or residing therein.

(b) For these purposes and for the purpose of determining whether or not a facility should be subject to the supervision of the department in accordance with section 902, the secretary, or other officer, inspector or agent of the department, shall have free and full access to the grounds, premises, and buildings of and to all the records, books or papers of or relating to any such State or supervised institution, and full opportunity to interrogate or interview any inmate thereof, or any person or persons committed to or being detained, treated or residing therein, and all persons connected with any such State or supervised institution as officers, or charged with the management, thereof, by law or otherwise, or in any way having the care, custody, control, or management thereof, or connected therewith as employes, are hereby directed and required to give to the secretary, or to such officer, inspector or agent of the department, such means, facilities and opportunity for such visitation, examination, inquiry and interrogation, as is hereby provided and required, or as the department, by its duly ordained rules or regulations, may require.

[See main volume for text of (c) and (d)]

As amended 1976, July 9, P.L. 993, No. 202, § 8, effective in 60 days.

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

Supplementary Index to Notes

Foster homes 2

1. Educational facilities
Girard College is a children's institution, and subject to supervision and visitation by department of public welfare. 1961 Op.Atty.Gen. No. 239.

2. Foster homes
Long-term foster placement may not be terminated without affording opportunity to foster parents and child of hearing at which they could challenge accuracy or sufficiency of reasons given for termination and at which interests of child in family relationship can be examined and determined. 1974 Op.Atty. Gen.No. 32.

§ 916. Recommendations

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

§ 921. Additional provisions respecting certain institutions; purpose; definitions; standards; inspection

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of Reorganization Plan No. 5 of 1973. See 71 P.S. § 755–5.

Cross References

Nursing home loans, see sections 1521.-101 to 1521.501 of this title.

1. In general

Legislature, as evidenced by 53 P.S. § 65762 which prohibits adoption of ordinance, bylaw, rule or regulation that interferes with operation of political subdivision of Commonwealth and which allows department of welfare to establish standards, not inconsistent with laws of Commonwealth, for safe and adequate care of individuals, intended not to subject state and county agencies to the preferences and vicissitudes of every township's local zoning and building regulations. Institution Dist. of Delaware County v. Middletown Tp., Delaware County, 299 A.2d 599, 450 Pa. 282, 1973.

County institution district was a "political subdivision" of the Commonwealth within Second Class Township Code provision prohibiting adoption of ordinance, bylaw, rule or regulation which interferes with, injures or affects operation of any other political subdivision or instrumentality of Commonwealth. Id.

To extent that department of public welfare regulation, requiring that a building designed for intermediate care of the incapacitated or infirm be approved by local or county building and zoning departments, attempted to limit 53 P.S. § 65762, prohibiting adoption of regulation which restricts, interferes with, injures or affects operation of any political subdivision of the Commonwealth, regulation was improper exercise of department's rule-making powers, and township zoning board could not, in absence of any valid statutory authority, restrict operation of county institution district. Id.

§ 922. Reorganization Plan No. 5 of 1955

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

ARTICLE X. DEPARTMENTAL POWERS AND DUTIES AS TO LICENSING

Reorganization Plan No. 3 of 1975

For provisions of Reorganization Plan No. 3 of 1975 relating to transfer of nursing home functions, powers and duties from Department of Public Welfare to Department of Health, see 71 P.S. § 756–3.

Suspended in Part

This article is suspended insofar as it is in conflict with the provisions of Reorganization Plan No. 3 of 1975. See section 7 of 71 P.S. § 756–3.

Reorganization Plan No. 2 of 1977

For provisions of Reorganization Plan No. 2 of 1977 relating to transfer from Department of Public Welfare to Governor's Council on Drug and Alcohol Abuse of functions, powers and duties relating to the regulation, supervision and licensing of drug and alcohol facilities, see 71 P.S. § 757–2.

Suspended in Part

This Article is suspended insofar as it is in conflict with the provisions of Reorganization Plan No. 2 of 1977. See 71 P.S. § 757–2.

(a) LICENSING PROVISIONS

Cross References

Abortion Control Act, see 35 P.S. §§ 6601 to 6608.

Medical and health related malpractice insurance, see 40 P.S. § 1301.101 et seq.

§ 1001. Definitions

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

Cross References

Child protective services, see 11 P.S. § 2201 et seq.

Health care professionals, peer review protection, see 63 P.S. §§ 425.1 to 425.4.

Nursing home loans, see sections 1521.-101 to 1521.501 of this title.

1. Construction and application

Mental retardation facility was not "nursing home" within meaning of that term as used in nursing home administrators licensure examination eligibility requirements. Bonham v. State Bd. of Examiners of Nursing Home Administrators, 375 A.2d 821, Cmwlth.1977.

§ 1002. Operation and maintenance without license prohibited

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

§ 1003. Application for license

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

§ 1006. Fees

Reorganization Plan No. 2, 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

§ 1007. Issuance of license

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2, of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

1. In general

Where nursing home premises had been sold, appeal from revocation of nursing home license would be quashed for mootness since even if license was improperly revoked, order of reinstatement would be of no effect because nursing home licenses must attach to specified premises. Com. Dept. of Health v. Baker Nursing Home, Inc., 369 A.2d 1336, 28 Pa.Cmwlth. 603, 1977.

Issuance of new license because of past violations by applicant, which had its nursing home license revoked but which, because of mootness, had received no judicial review of merits of department of health's findings as to such violations, would not be precluded by this section, which only requires refusal of application for license for nursing home or operation that does not conform to law or regulation at time of application. Id.

In proceeding for licensing of individual and certain organizations to operate group homes for mentally retarded persons, evidence concerning conditions and occurrences at facility run by separate corporation was relevant and properly admitted where nexus was shown between the parties and such corporation; fact that parties were not directly involved in day-to-day operations of facility run by separate corporation was correctly considered in weighing evidence and constituted proper exercise of fact-finding powers of secretary of public welfare. Grady v. Com., Dept. of Public Welfare, 336 A.2d 468, 18 Pa.Cmwlth. 482, 1975.

In proceeding for licensing of individuals and organizations to operate group homes for mentally retarded persons, record which was devoid of any evidence or findings concerning group homes criteria set forth in regulations, i. e., budgeting, staffing, expensing, living arrangements, etc., was totally inadequate to show fulfillment of administrative process, and remand for additional evidence and findings of fact and conclusions of law was necessary. Id.

§ 1008. Provisional license

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

§ 1009. Term and content of license

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755–2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755–2.

1. In general

Where nursing home premises had been sold, appeal from revocation of nursing home license would be quashed for mootness since even if license was improperly revoked, order of reinstatement would be of no effect because nursing home licenses must attach to specified premises. Com. Dept. of Health v. Baker Nursing Home, Inc., 369 A.2d 1336, 28 Pa.Cmwlth. 603, 1977.

§ 1111. Commissioner of Mental Health

1. In general

Removed civil servant did not have standing to contest validity of appointment of acting superintendent of state hospital and her authority to suspend and remove him from his position where acting superintendent did so in her capacity, uncontested in the record, as acting superintendent. Foster v. Com., State Civil Service Commission, 321 A.2d 409, 14 Pa.Cmwlth. 251, 1974.

§ 1016. Right to enter and inspect

For the purpose of determining the suitability of the applicants and of the premises or whether or not any premises in fact qualifies as a facility as defined in section 1001 of this act [1] or the continuing conformity of the licensees to this act and to the applicable regulations of the department, any authorized agent of the department shall have the right to enter, visit and inspect any facility licensed or requiring a license under this act and shall have full and free access to the records of the facility and to the individuals therein and full opportunity to interview, inspect or examine such individuals.

An authorized agent of the department shall also confer with the operators of facilities regarding the minimum standards of the department,

encourage the adoption of higher standards and recommend methods of improving care and services.

As amended 1976, July 9, P.L. 993, No. 202, § 9, effective in 60 days.

1 Section 1001 of this title.

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended In Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

§ 1018. Records

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended In Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

§ 1021. Regulations

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

§ 1026. Refusal to issue license; revocation; notice

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

1. In general

Where Pennsylvania department of health issued a rule to show cause why nursing home's license should not be revoked because of failure to correct certain alleged deficiencies, and during pendency of administrative proceedings the home filed a complaint seeking to enjoin the officials from proceeding with the hearing, the Commonwealth Court erred in issuing a preliminary injunction suspending the hearing in absence of evidence that the home would suffer irreparable harm while pursuing its rights in the proceedings, the right to continue to operate the home was not affected during the pendency of the proceedings, and at time the injunction was issued, it was not yet known whether administrative proceedings would result in final order favorable or unfavorable to the home. Colonial Gardens Nursing Home, Inc. v. Bachman, 373 A.2d 748, 473 Pa. 56, 1977.

Issuance of new license because of past violations by applicant, which had its nursing home license revoked but which, because of mootness, had received no judicial review of merits of department of health's findings as to such violations, would not be precluded by this section, which only requires refusal of application for license for nursing home or operation that does not conform to law or regulation at time of application. Com. Dept. of Health v. Baker Nursing Home, Inc., 369 A.2d 1336, 28 Pa.Cmwlth. 603, 1977.

Where nursing home premises had been sold, appeal from revocation of nursing home license would be quashed for mootness since even if license was improperly revoked, order of reinstatement would be of no effect because nursing home licenses must attach to specified premises. Id.

§ 1031. Violation; penalty

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

(b) INJUNCTIONS AGAINST UNLICENSED ACTIVITIES; PROCEDURES

§ 1051. Definition

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

§ 1052. Actions against unlicensed institutions

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

§ 1053. Actions against violations of law and rules and regulations

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

§ 1054. Venue

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

1. **Construction and application**

Under this section providing that actions authorized by the code shall be instituted in the court of common pleas in the county where the alleged unauthorized activity is committed, and under 17 P.S. § 211.401, affording to the Commonwealth Court original jurisdiction with the several courts of common pleas, Commonwealth Court possessed original concurrent jurisdiction over action by welfare department for injunctive and other equitable relief against nursing home. Com. Dept. of Health v. Crown Nursing Home, 362 A.2d 491, 26 Pa. Cmwlth. 7, 1976.

§ 1055. Injunction or restraining order when appeal is pending

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

§ 1056. Injunction or restraining order when no appeal is pending

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

§ 1057. Repealed. 1971, June 3, P.L. 146, No. 6, § 1 (§ 309(a)(176))

§ 1058. Bonds and costs

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

§ 1059. Law supplementary

Reorganization Plan No. 2 of 1973

For provisions of Reorganization Plan No. 2 of 1973 affecting this section, see 71 P.S. 755-2.

Suspended in Part

This section is suspended insofar as it is in conflict with the provisions of the Reorganization Plan No. 2 of 1973. See section 3 of 71 P.S. Section 755-2.

ARTICLE XI. MENTAL HEALTH: DEPARTMENTAL POWERS AND DUTIES; COMMISSIONER OF MENTAL HEALTH; INTERSTATE COMPACT; RECIPROCAL AGREEMENTS; RESEARCH FOUNDATION

(a) DEPARTMENTAL POWERS AND DUTIES; COMMISSIONER OF MENTAL HEALTH

§ 1101. Mental health: departmental powers and duties

Cross References

Mental health procedures, see 50 P.S. § 7101 et seq.

(b) INTERSTATE COMPACT ON MENTAL HEALTH

§ 1121. Authorization; compact provisions

Complementary Laws:

Ala.—Code of Ala.1975, §§ 22-55-1 to 22-55-4.
Ark.—Ark.Stats. §§ 59-801 to 59-806.
Colo.—C.R.S. '73, 24-60-1001 to 24-60-1006.
D.C.—D.C.C.E. §§ 6-1601 to 6-1606.
Fla.—West's F.S.A. §§ 394.479 to 394.484.
Ga.—Code, §§ 99-3801 to 99-3817.
Hawaii—HRS §§ 335-1 to 335-5.
Idaho—I.C. § 66-1201 et seq.
Ind.—I.C.1971, 16-13-8-1 to 16-13-8-5.
Kan.—K.S.A. 65-3101 et seq.
Ky.—KRS 210.520 to 210.550.
Md.—Code 1957, art. 41, §§ 319 to 338.
Mich.—M.C.L.A. §§ 330.1920 to 330.1930.
Mont.—R.C.M.1947, § 80-2412.
Neb.—R.R.S.1943, §§ 83-801 to 83-806.
N.M.—1953 Comp. §§ 34-5-1 to 34-5-5.
N.Y.—McK. Mental Hygiene Law, § 67.07.
N.C.—G.S. §§ 122-99 to 122-104.
N.D.—NDCC 25-11-01 to 25-11-06.
Ore.—ORS 428.310 to 428.330.
R.I.—Gen.Laws 1956, § 26-6-1 et seq.
S.C.—Code 1962, §§ 32-1051 to 32-1056.
S.D.—SDCL 27A-6-1 to 27A-6-5.
Tenn.—T.C.A. §§ 33-1501 to 33-1506.
Texas—Vernon's Ann.Civ.St. art. 5561f, §§ 1-6.
Vt.—18 V.S.A. §§ 9001 to 9014.
Va.—Code 1950, §§ 37.1-190 to 37.1-193.
W.Va.—Code, 27-14-1 to 27-14-5.
Wyo.—W.S.1957, §§ 25-90 to 25-95.

ACT 148

Act 148, which became effective January 1, 1978, amends the Public Welfare Code, specifically Sections 346 and 359 of Article III and Section 704 of Article VII. It also repeals Section 36 of the Juvenile Act, regarding costs for the care of court-ordered children. The Act was designed to encourage the use of appropriate community alternatives to institutions, by structuring the Department's reimbursement to counties for children and youth services as follows:

1. 80% of the cost of subsidized adoption;
2. Between 75% and 90% of reasonable costs including but not limited to staff costs of child welfare services and services approved by the Department such as foster care, group home care, day treatment, community residential care, service to children in their own homes, and other approved alternative programs. (The implementing regulations permit the 90% reimbursement level for shelter care provided in foster family care or group homes established after August 3, 1977, to meet the additional needs created by the reclassification of status offenders as dependent children.)
3. 60% of other reasonable child welfare administrative costs;
4. 50% of the cost of care of children placed by a child welfare agency in, or committed by the court to the legal custody of, an approved facility <u>other</u> than those described in #2 above (i.e. YDC's and YFC's, and other secure and non-secure institutional programs);
5. 50% of reasonable medical and other expenses incurred in proceedings under the Juvenile Act.

Act 148 also required that each county submit to the Department, for approval, its comprehensive annual plan and budget estimate for children and youth services, including services which will be used by the Juvenile Court.

The Act establishes the procedure for reimbursements and adjustments for county child welfare expenditures. At the end of 1978, and again at the end of 1979, any county incurring increased expenses under the new system than under the old system (as of 1976) will be eligible for a grant in the amount of the difference. In addition, under Act 148 the Department can make grants to counties for establishing new services to children, for up to 3 years of operation.

In developing regulations to implement Act 148, the Department has:

1. set minimum standards for the operation in each county of a Single County Children and Youth Social Service Agency, generally known as the Child Welfare Agency. In addition, each county is responsible for developing the annual plan and estimate for children and youth services due to the Department of Public Welfare on November 15. Citizen input and public hearings are a required part of the planning process. Other components of the plan involve a resource inventory to identify all service agencies in a county and services available through those agencies, and an evaluation procedure to ensure periodic review to determine whether the stated goals and objectives of the plan and estimate are being achieved.
2. defined the State/county relationship in funding those Single County Agency programs;
3. establish minimum standards for funding new services to counties;
4. prescribed the specific minimum rates of financial reimbursements in which the Department will participate.

In addition, the Department is revising or developing the other regulations required to implement Act 148, specifically those governing private children and youth social service agencies, and those which define and govern the actual services provided to children and youth, such as foster care, group home care and the like.

The legislation and the implementing regulations are designed to assist in the development of a service delivery system which makes the maximum use of all of the available resources to identify and meet the needs of children and young people. If the planning process is effectively carried out, it should go a long way toward eliminating the fragmentation and gaps in service that have for too long characterized the services for children and youth.

Act 41 SESSION OF 1977

DELINQUENT AND DEPENDENT CHILDREN

ACT NO. 1977–41

S.B.NO.757

An Act amending the act of December 6, 1972 (P.L. 1464, No. 333), entitled "An act relating to the care, guidance, control, trial, placement and commitment of delinquent and deprived children," further defining "child," "delinquent act," and "deprived child," further defining certain words, changing certain references from "deprived" to "dependent," further providing for informal adjustment and consent decrees, further regulating detention and shelter care and imposing certain duties on counties and the Department of Public Welfare, further providing for transfers and for the disclosure of certain records, making related changes and making certain repeals and providing an appropriation.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1.

Clauses (1), (2), (3), (4) and (6) of section 2, section 3, subsection (a) of section 4, subsection (a) of section 8, subsection (c) of section 8.1, sections 9, 14 and 14.1, subsections (a) and (b) of section 15, subsection (a) of section 18, subsection (a) of section 22, subsections (a), (b) and (c) of section 23, sections 24, 25 and 26, subsection (a) of section 27, clause (4) of subsection (a) of section 28, and sections 31, 32 and 38, act of December 6, 1972 (P.L. 1464, No. 333), known as the "Juvenile Act," are amended or added to read:

Section 2. Definitions.[90]

As used in this act:

(1) "Child" means an individual who is: (i) under the age of eighteen years; or (ii) under the age of twenty-one years who committed an act of delinquency before reaching the age of eighteen years; or who was adjudicated dependent before reaching the age of eighteen years and who, while engaged in a course of instruction or treatment, requests the court to retain jurisdiction until the course has been completed, but in no event shall a child remain in a course of instruction or treatment past the age of twenty-one years.

(2) "Delinquent act" means an act designated a crime under the law of this State, or of another state if the act occurred in that state, or under Federal law, or under local ordinances. "Delinquent act" shall not include the crime of murder nor shall it include summary offenses unless the child fails to pay a fine levied thereunder, in which event notice of such fact shall be certified to the court. No child shall be detained, committed or sentenced to imprisonment by a district magistrate, municipal court judge, or traffic court judge.

(3) "Delinquent child" means a child ten years of age or older whom the court has found to have committed a delinquent act and is in need of treatment, supervision or rehabilitation.

(4) "Dependent child" means a child who: (i) is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, or morals; or (ii) has been placed for care or adoption in violation of law;

90. 11 P.S. § 50—102, cls. (1) to (4); cl. (6).

or (iii) has been abandoned by his parents, guardian, or other custodian; or (iv) is without a parent, guardian, or legal custodian; or (v) while subject to compulsory school attendance is habitually and without justification truant from school; '(vi) has committed a specific act or acts of habitual disobedience of the reasonable and lawful commands of his parent, guardian or other custodian and who is ungovernable and found to be in need of care, treatment or supervision; (vii) is under the age of ten years and has committed a delinquent act; or (viii) has been formerly adjudicated dependent, and is under the jurisdiction of the court, subject to its conditions or placements and who commits an act which is defined as ungovernable in section 2(4)(vi); or a child who has been referred pursuant to section 8,[91] and who commits an act which is defined as ungovernable in section 2(4)(vi).

* * *

(6) "Protective supervision" means supervision ordered by the court of children found to be dependent.

* * *

Section 3. Jurisdiction.[92]

This act shall apply exclusively to the following:

(1) Proceedings in which a child is alleged to be delinquent or dependent.

(2) Proceedings arising under sections 32 through 35.[93]

(3) Transfers arising under section 7.[94]

(4) Proceedings under the "Interstate Compact on Juveniles," section 731, act of June 13, 1967 (P.L. 31, No. 21), known as the "Public Welfare Code." [95]

Section 4. Powers and Duties of Probation Officers.[96]

(a) For the purpose of carrying out the objectives and purposes of this act, and subject to the limitations of this act or imposed by the court, a probation officer shall:

(1) Make investigations, reports, and recommendations to the court.

(2) Receive and examine complaints and charges of delinquency or dependency of a child for the purpose of considering the commencement of proceedings under this act.

(3) Supervise and assist a child placed on probation or in his protective supervision or care by order of the court or other authority of law.

(4) Make appropriate referrals to other private or public agencies of the community if their assistance appears to be needed or desirable.

(5) Take into custody and detain a child who is under his supervision or care as a delinquent or dependent child if the probation officer has reasonable cause to believe that the child's health or safety is in imminent danger, or that he may abscond or be removed from the jurisdiction of the court, or when ordered by the court pursuant to this act or that he violated the conditions of his probation.

(6) Perform all other functions designated by this act or by order of the court pursuant thereto.

* * *

Section 8. Informal Adjustment.[97]

(a) Before a petition is filed, the probation officer or other officer of the court designated by it, subject to its direction, shall, in the case of a dependent child where the court's jurisdiction is premised upon the provisions of section 2(4)(i), (ii), (iii), (iv), (v), or (vii) [98] and if otherwise appropriate, refer the child and his parents to any public or private social agency available for assisting in the matter. Upon referral, the agency shall indicate its willingness to accept the child and shall report back to the referring officer within three months concerning the status of

91. 11 P.S. § 50—304.
92. 11 P.S. § 50—103.
93. 11 P.S. §§ 50—329 to 50—332.
94. 11 P.S. § 50—303.
95. 62 P.S. § 731.
96. 11 P.S. § 50-201, subsec. (a).
97. 11 P.S. § 50—304, subsec. (a).
98. 11 P.S. § 50-102, subsecs. (4)(i) to (4)(v), (4)(vii).

the referral. Similarly, the probation officer may in the case of a delinquent child, or a dependent child where the court's jurisdiction is permitted in section 2(4)(vi)[99] refer the child and his parents to an agency for assisting in the matter. The agency may return the referral to the probation officer or other officer for further informal adjustment if it is in the best interests of the child.

* * *

Section 8.1. Consent Decree.[1]

* * *

(c) A consent decree shall remain in force for six months unless the child is discharged sooner by probation services with the approval of the court. Upon application of probation services or other agency supervising the child, made before expiration of the six-month period, a consent decree may be extended by the court for an additional six months.

* * *

Section 9. Venue.[2]

A proceeding under this act may be commenced (i) in the county in which the child resides, or (ii) if delinquency is alleged, in the county in which the acts constituting the alleged delinquency occurred, or (iii) if dependency is alleged, in the county in which the child is present when it is commenced.

Section 14. Place of Detention.[3]

(a) A child alleged to be delinquent may be detained only in:

(1) A licensed foster home or a home approved by the court;

(2) A facility operated by a licensed child welfare agency or one approved by the court;

(3) A detention home, camp, center or other facility for delinquent children which is under the direction or supervision of the court or other public authority or private agency, and is approved by the Department of Public Welfare; or

(4) Any other suitable place or facility, designated or operated by the court and approved by the Department of Public Welfare. Under no circumstances shall a child be detained, in any facility with adults, or where he or she is apt to be abused by other children. Until December 31, 1979, a child may be detained in a facility with adults if there is no appropriate facility available within a reasonable distance or a contiguous county, whichever is nearer, for the detention of the child in which case the child shall be kept separate and apart from such adults at all times and shall be detained under such circumstances for not more than five days.

(b) The official in charge of a jail or other facility for the detention of adult offenders or persons charged with crime shall inform the court immediately if a person who is or appears to be under the age of eighteen years is received at the facility and shall bring him before the court upon request or deliver him to a detention or shelter care facility designated by the court.

(b.1) After December 31, 1979, it shall be unlawful for any person in charge of or employed by a jail knowingly to receive for detention or to detain in such jail any person who he has or should have reason to believe is a child. Until such time, a jail may be used for the detention of a child who is alleged to be delinquent only if such detention is necessary for the safety of the public and if such jail has been approved for the detention of such child by the Department of Public Welfare in good faith and such detention has been ordered by the court. The Department of Public Welfare shall approve for use for purposes of and in accordance with the provisions of this section any jail which it finds maintains, for the detention of any such child, an appropriate room under adequate super-

99. 11 P.S. § 50—102, subsec. (4)(vi).
1. 11 P.S. § 50—305, subsec. (c).
2. 11 P.S. § 50—306.
3. 11 P.S. § 50—311.

vision: Provided, That the Department of Public Welfare shall, no later than sixty days after the effective date of the act, by regulation promulgate standards governing the operations of such provisions of such jails as are used for the detention of children pursuant to this section and shall cause such jails to be inspected by the Department of Public Welfare at least once every six months until this confinement is terminated in accordance with provisions in this act.

(c) If a case is transferred for criminal prosecution the child may be transferred to the appropriate officer or detention facility in accordance with the law governing the detention of persons charged with crime. The court in making the transfer may order continued detention as a juvenile pending trial if the child is unable to provide bail.

(d) A child alleged to be dependent may be detained or placed only in a Department of Public Welfare approved shelter care facility as stated in clauses (1), (2) and (4) of subsection (a), and shall not be detained in a jail or other facility intended or used for the detention of adults charged with criminal offenses, but may be detained in the same shelter care facilities with alleged delinquent children.

(e) The Department of Public Welfare shall develop or assist in the development in each county of the Commonwealth approved programs for the provision of shelter care for children referred to or under the jurisdiction of the court.

(f)(1) Each county, acting alone or in conjunction with other counties as provided in section 14.1,[4] shall by December 31, 1978, submit to the Department of Public Welfare for approval a plan for the removal of children from adult facilities. If no such plan is submitted or accepted by the department within the allocated period, the department, after determining the detention needs of individual counties, shall thereafter take whatever steps it deems necessary to provide the required detention services for any such county or counties; including the construction of a regional detention facility to meet the needs of the counties insofar as is consistent with prohibitions against the use of adult facilities for juvenile offenders as herein provided. The department, after exhausting all other available funds including law enforcement assistance administration funds and any other Federal or State funds available for such purpose, shall charge the cost of establishing the necessary regional detention facilities to the counties that will utilize its services.

(2) The amount due the Commonwealth for the services or facilities provided pursuant to clause (1) shall be paid by the county within fifteen months after receipt of notice of the amount due. In determining the amount which each county shall be charged for the establishment of a regional detention facility, the department shall take into account the extent to which the participating counties shall utilize the facilities.

(3) Except as provided in clause (4), the charges made by the department against any county pursuant to this subsection shall not exceed $50,000.

(4) In addition to the charges authorized for the providing of regional detention facilities and notwithstanding the limitations on such charges set forth in clause (3), the Commonwealth shall be entitled to an additional amount for providing such facilities equivalent to 7% of the costs imposed on the county.

(5) All sums collected from the counties pursuant to this subsection shall be paid into the general fund and credited to the Department of Public Welfare.

Section 14.1. Regional Detention Facilities.[5]

(a) Where the operation of an approved detention facility by a single county would not be feasible, economical or conducive to the best in-

4. 11 P.S. § 50—311.1.
5. 11 P.S. § 50—311.1.

terest of a child needing detention care, the Department of Public Welfare shall:

(1) Make provisions directly or by contract with a single county for the implementation and operation, in accordance with the regulations promulgated by the Department of Public Welfare of regional detention facilities serving the needs of two or more counties.

(2) Arrive at mutually agreeable arrangements with counties participating in the use of such regional detention facilities for the equitable sharing in the costs of constructing and operating such regional detention facilities, including necessary expenditures to transport children and, if financially indigent, their parents, guardians, or custodians to and from such regional detention facilities with funds contributed by the State and by such counties. The department shall only operate a regional detention facility, established under subsection (f) of section 14,[6] upon refusal of the counties participating in its use to operate the facility pursuant to department regulations.

(b) The Department of General Services shall make available any vacant Commonwealth building which the Department of Public Welfare certifies as appropriate for renovation as a regional detention facility.

Section 15. Release from Detention or Shelter Care; Hearing; Conditions of Release.[7]

(a) If a child is brought before the court or delivered to a detention or shelter care facility designated by the court, the intake or other authorized officer of the court shall immediately make an investigation and release the child unless it appears that his detention or shelter care is warranted or required under section 12.[8] The release of the child shall not prevent the subsequent filing of a petition as provided in this act. If he is not so released, a petition shall be promptly made and presented to the court within twenty-four hours or the next court business day of the child's admission to detention or shelter care.

(b) An informal hearing shall be held promptly by the court or the master and not later than seventy-two hours after the child is placed in detention or shelter care to determine whether his detention or shelter care is required under section 12 and if the child is alleged to be delinquent, that probable cause exists that the child has committed a delinquent act. Reasonable notice thereof, either oral or written, stating the time, place, and purpose of the hearing shall be given to the child and if they can be found, to his parents, guardian, or other custodian. Prior to the commencement of the hearing the court or master shall inform the parties of their right to counsel and to appointed counsel if they are needy persons, and of the child's right to remain silent with respect to any allegations of delinquency.

* * *

Section 18. Summons.[9]

(a) After the petition has been filed the court shall fix a time for hearing thereon, which, if the child is in detention or shelter care, shall not be later than ten days after the filing of the petition. If the hearing is not held within such time, the child shall be immediately released from detention or shelter care. A child may be detained or kept in shelter care for an additional single period not to exceed ten days where the court determines at a hearing that evidence material to the case is unavailable and due diligence to obtain such evidence has been exercised and there are reasonable grounds to believe that such evidence will be available at a later date and the court finds by clear and convincing evidence that the child's life would be in danger, the community would be exposed to a specific danger or that the child will abscond or be removed from the jurisdiction of the court. The court shall direct the issuance of a sum-

6. 11 P.S. § 50—311, subsec. (f).
7. 11 P.S. § 50—312, subsecs. (a), (b).
8. 11 P.S. § 50—309.
9. 11 P.S. § 50—315, subsec. (a).

mons to the parents, guardian, or other custodian, a guardian ad litem, and any other persons as appear to the court to be proper or necessary parties to the proceeding, requiring them to appear before the court at the time fixed to answer the allegations of the petition. The summons shall also be directed to the child if he is fourteen or more years of age or is alleged to be a delinquent. A copy of the petition shall accompany the summons.

* * *

Section 22. Investigation and Report.[10]

(a) If the allegations of a petition are admitted by a party or notice of hearing under section 28 [11] has been given, the court, prior to the hearing on need for treatment or disposition, may direct that a social study and report in writing to the court be made by an officer of the court or other person designated by the court, concerning the child, his family, his environment, and other matters relevant to disposition of the case. If the allegations of the petition are not admitted and notice of a hearing under section 28 has not been given, the court shall not direct the making of the study and report until after the court has heard the petition upon notice of hearing given pursuant to this act and the court has found that the child committed a delinquent act or is a dependent child.

* * *

Section 23. Hearing; Findings; Dismissal.[12]

(a) After hearing the evidence on the petition the court shall make and file its findings as to whether the child is a dependent child, or if the petition alleges that the child is delinquent, whether the acts ascribed to the child were committed by him. If the court finds that the child is not a dependent child or that the allegations of delinquency have not been established it shall dismiss the petition and order the child discharged from any detention or other restriction theretofore ordered in the proceeding.

(b) If the court finds on proof beyond a reasonable doubt that the child committed the acts by reason of which he is alleged to be delinquent it shall enter such finding on the record and it shall then proceed immediately or at a postponed hearing, which shall occur not later than twenty days after adjudication if the child is in detention, to hear evidence as to whether the child is in need of treatment, supervision or rehabilitation and to make and file its findings thereon. In the absence of evidence to the contrary, evidence of the commission of acts which constitute a felony shall be sufficient to sustain a finding that the child is in need of treatment, supervision or rehabilitation. If the court finds that the child is not in need of treatment, supervision or rehabilitation it shall dismiss the proceeding and discharge the child from any detention or other restriction theretofore ordered.

(c) If the court finds from clear and convincing evidence that the child is dependent, the court shall proceed immediately or at a postponed hearing, which shall occur not later than twenty days after adjudication if the child has been removed from his home, to make a proper disposition of the case.

* * *

Section 24. Disposition of Dependent Child.[13]

(a) If the child is found to be a dependent child the court may make any of the following orders of disposition best suited to the protection and physical, mental, and moral welfare of the child:

(1) Permit the child to remain with his parents, guardian, or other custodian, subject to conditions and limitations as the court prescribes, including supervision as directed by the court for the protection of the child.

10. 11 P.S. § 50—319, subsec. (a).
11. 11 P.S. § 50—325.
12. 11 P.S. § 50—320, subsecs. (a), (b), and (c).
13. 11 P.S. § 50—321.

(2) Subject to conditions and limitations as the court prescribes transfer temporary legal custody to any of the following: (i) any individual in or outside Pennsylvania who, after study by the probation officer or other person or agency designated by the court, is found by the court to be qualified to receive and care for the child; (ii) an agency or other private organization licensed or otherwise authorized by law to receive and provide care for the child or (iii) a public agency authorized by law to receive and provide care for the child.

(3) Without making any of the foregoing orders transfer custody of the child to the juvenile court of another state if authorized by and in accordance with section 32.[14]

(b) Unless a child found to be dependent is found also to be delinquent he shall not be committed to or confined in an institution or other facility designed or operated for the benefit of delinquent children.

(c) Every county of the Commonwealth shall develop programs for children under section 2(4)(v) or (vi).[15]

Section 25. Disposition of Delinquent Child.[16]

If the child is found to be a delinquent child the court may make any of the following orders of disposition best suited to his treatment, supervision, rehabilitation, and welfare:

(1) Any order authorized by section 24 [17] for the disposition of a dependent child.

(2) Placing the child on probation under supervision of the probation officer of the court or the court of another state as provided in section 34 [18], under conditions and limitations the court prescribes.

(3) Committing the child to an institution, youth development center, camp, or other facility for delinquent children operated under the direction or supervision of the court or other public authority and approved by the Department of Public Welfare.

(4) If the child is twelve years of age or older, committing the child to an institution operated by the Department of Public Welfare. In selecting from the alternatives set forth in this section, the court shall follow the general principle that the disposition imposed should provide the means through which the provisions of this act are executed and enforced consistent with section 1 [19] and when confinement is necessary, the court shall impose the minimum amount of confinement that is consistent with the protection of the public and the rehabilitation needs of the child.

(5) Ordering payment by the child of reasonable amounts of money as fines, costs or restitution as deemed appropriate as part of the plan of rehabilitation considering the nature of the acts committed and the earning capacity of the child.

(6) An order of the terms of probation may include an appropriate fine considering the nature of the act committed or restitution not in excess of actual damages caused by the child which shall be paid from the child's earnings received through participation in a constructive program of service or education acceptable to the victim and the court whereby, during the course of such service, the child shall be paid not less than the State's minimum wage. In ordering such service, the court shall take into consideration the child's age, physical and mental capacity and the service shall be designed to impress upon the child a sense of responsibility for the injuries caused to the person or property of another. The court's order shall be limited in duration consistent with the limitations in section 26 [20] and in the act of May 13, 1915 (P.L. 286, No. 177), known as the "Child Labor Law." [21] The court order shall specify the nature of the work, the number of hours to be spent performing the assigned tasks, and shall further specify that as part of a plan of treatment and rehabilita-

14. 11 P.S. § 50—329.
15. 11 P.S. § 50—102, subsec. (4)(v), (4)(vi).
16. 11 P.S. § 50—322.
17. 11 P.S. § 50—321.
18. 11 P.S. § 50—331.
19. 11 P.S. § 50—101.
20. 11 P.S. § 50—323.
21. 43 P.S. § 411 et seq.

tion that up to 75% of the child's earnings be used for restitution in order to provide positive reinforcement for the work performed.

Section 26. Limitation on Commitment.[22]

(a) No child shall initially be committed to an institution for a period longer than three years or a period longer than he could have been sentenced by the court if he had been convicted of the same offense as an adult, whichever is less. The initial commitment may be extended for a similar period of time, or modified, if the court finds after hearing that the extension or modification will effectuate the original purpose for which the order was entered. The child shall have notice of the extension or modification hearing and shall be given an opportunity to be heard. The committing court shall review each commitment every six months and shall hold a disposition review hearing at least every nine months

(b) After placement of the child, and if his progress with the institution warrants it, the institution may seek to transfer said child to a less secure facility, including a group home or foster boarding home. The institution shall give the committing court written notice of such transfer. If the court does not object to such transfer within ten days after receipt of the notice, such transfer may be effectuated. If the court objects to such transfer, it shall hold a hearing within twenty days after objecting to the transfer for the purpose of reviewing its commitment order. If the institution seeks to transfer to a more secure facility the child must have a full hearing before the committing court. At the hearing, the court may reaffirm or modify its commitment order.

(c) Immediately after the Commonwealth adopts its budget, the Department of Public Welfare shall notify the courts and the legislature, for each Department of Public Welfare region, of the available: (i) secure beds for the serious juvenile offenders; (ii) general residential beds for the adjudicated delinquent child; and (iii) the community-based programs for the adjudicated delinquent child. If the population at a particular institution or program exceeds 110% of capacity, the department shall notify the courts and the legislature that intake to that institution or program is temporarily closed and shall make available equivalent services to children in equivalent facilities.

Section 27. Order of Adjudication; Noncriminal.[23]

(a) An order of disposition or other adjudication in a proceeding under this act is not a conviction of crime and does not impose any civil disability ordinarily resulting from a conviction or operate to disqualify the child in any civil service application or appointment. A child shall not be committed or transferred to a penal institution or other facility used primarily for the execution of sentences of adults convicted of a crime.

* * *

Section 28. Transfer.[24]

(a) After a petition has been filed alleging delinquency based on conduct which is designated a crime or public offense under the laws, including local ordinances, of this State, the court before hearing the petition on its merits may rule that this act is not applicable and that the offense should be prosecuted, and transfer the offense, where appropriate, to the trial or criminal division or to a judge of the court assigned to conduct criminal proceedings, for prosecution of the offense if:

* * *

(4) The court finds that there is a prima facie case that the child committed the delinquent act alleged, and that the delinquent act would be considered a felony if committed by an adult, and the court finds that there are reasonable grounds to believe that: (i) the child is not amenable to treatment, supervision or rehabilitation as a juvenile through available facilities, In determining this the court may consider age, mental capacity, maturity, previous record and probation or institutional reports;

22. 11 P.S. § 50—323.
23. 11 P.S. § 50—324, subsec. (a).
24. 11 P.S. § 50—325, subsec. (a)(4).

and (ii) the child is not committable to an institution for the mentally retarded or mentally ill; and (iii) the interests of the community require that the child be placed under legal restraint or discipline or that the offense is one which would carry a sentence of more than three years if committed as an adult.

* * *

Section 31. Disposition of Nonresident Child.[25]

(a) If the court finds that a child who has been adjudged to have committed a delinquent act or to be dependent is or is about to become a resident of another state which has adopted the Uniform Juvenile Court Act, or a substantially similar act which includes provisions corresponding to this section and section 32 hereof,[26] the court may defer hearing on need of treatment and disposition and request by any appropriate means the appropriate court of the county of the child's residence or prospective residence to accept jurisdiction of the child.

(b) If the child becomes a resident of another state while on probation or under protective supervision under order of a court of this State, the court may request the court of the state in which the child has become a resident to accept jurisdiction of the child and to continue his probation or protective supervision.

(c) Upon receipt and filing of an acceptance the court of this state shall transfer custody of the child to the accepting court and cause him to be delivered to the person designated by that court to receive his custody. It also shall provide that court with certified copies of the order adjudging the child to be a delinquent, or dependent child, of the order of transfer, and if the child is on probation or under protective supervision under order of the court, of the order of disposition. It also shall provide that court with a statement of the facts found by the court of this State and any recommendations and other information or documents it considers of assistance to the accepting court in making a disposition of the case or in supervising the child on probation or otherwise.

(d) Upon compliance with subsection (c) the jurisdiction of the court of this State over the child is terminated.

Section 32. Disposition of Resident Child Received from Another State.[27]

(a) If a juvenile court of another state which has adopted the Uniform Juvenile Court Act, or a substantially similar act which includes provisions corresponding to section 31 [28] and this section, requests a court of this State to accept jurisdiction of a child found by the requesting court to have committed a delinquent act or to be an unruly or dependent child, and the court of this State finds, after investigation that the child is, or is about to become, a resident of the county in which the court presides, it shall promptly and not later than fourteen days after receiving the request issue its acceptance in writing to the requesting court and direct its probation officer or other person designated by it to take physical custody of the child from the requesting court and bring him before the court of this State or make other appropriate provisions for his appearance before the court.

(b) Upon the filing of certified copies of the orders of the requesting court (i) determining that the child committed a delinquent act or an unruly or dependent child, and (ii) committing the child to the jurisdiction of the court of this State, the court of this State shall immediately fix a time for a hearing on the need for treatment, supervision or rehabilitation and disposition of the child or on the continuance of any probation or protective supervision.

(c) The hearing and notice thereof and all subsequent proceedings are governed by this act. The court may make any order of disposition per-

25. 11 P.S. § 50—328.
26. 11 P.S. § 50—329.
27. 11 P.S. § 50—329.
28. 11 P.S. § 50—328.

mitted by the facts and this act. The orders of the requesting court are conclusive that the child committed the delinquent act or is an unruly or dependent child and of the facts found by the court in making the orders. If the requesting court has made an order placing the child on probation or under protective supervision, a like order shall be entered by the court of this State.

Section 38. Law Enforcement Records.[29]

(a) Law enforcement records and files concerning a child shall be kept separate from the records and files of arrests of adults. Unless a charge of delinquency is transferred for criminal prosecution under section 28,[30] the interest of national security requires, or the court otherwise orders in the interest of the child, the records and files shall not be open to public inspection or their contents disclosed to the public except as provided in subsection (b); but inspection of the records and files is permitted by:

(1) The court having the child before it in any proceeding;

(2) Counsel for a party to the proceeding;

(3) The officers of institutions or agencies to whom the child is committed;

(4) Law enforcement officers of other jurisdictions when necessary for the discharge of their official duties; and

(5) A court in which he is convicted of a criminal offense for the purpose of a presentence report or other dispositional proceeding, or by officials of penal institutions and other penal facilities to which he is committed, or by a parole board in considering his parole or discharge or in exercising supervision over him.

(b)(1) The contents of law enforcement records and files concerning a child shall not be disclosed to the public except if the child is fourteen or more years of age at the time of the alleged conduct and if:

(i) The child has been adjudicated delinquent by a court as a result of an act or acts which include the elements of rape, kidnapping, murder, robbery, arson, burglary or other act involving the use of or threat of serious bodily harm; or

(ii) A petition alleging delinquency has been filed by a law enforcement agency alleging that the child has committed an act or acts which include the elements of rape, kidnapping, murder, robbery, arson, burglary or other act involving the use of or threat of serious bodily harm and the child previously has been adjudicated delinquent by a court as a result of an act or acts which included the elements of one of such crimes.

(2) If the child's conduct meets the requirements for disclosure as set forth in paragraph (1), then the court or law enforcement agency, as the case may be, shall disclose the name of the child and the nature of the conduct in question.

Section 2.[31]

Subsection (b) of section 343, act of June 13, 1967 (P.L. 31, No. 21), known as the "Public Welfare Code," is repealed.

Section 3.

The sum of $1,500,000, or as much thereof as may be necessary, is hereby appropriated to the Department of Public Welfare to be used by the department to implement the provisions of section 14.1[32] and to provide grants to counties for the same purpose. Excluding probation services, no county shall be required to pay more than 10% of the costs of operating new shelter care programs required to implement the reclassification provided for in section 2(4)(vi),[33] provided that the county:

(1) Has applied for existing Federal funds to implement section 2(4)(vi);

29. 11 P.S. § 50—335.
30. 11 P.S. § 50—325.
31. 62 P.S. § 343, subsec. (b) Rep.
32. 11 P.S. § 50—311.1.
33. 11 P.S. § 50—102, subsec. (4)(vi).

(2) The county has not been deemed ineligible for these Federal funds; and

(3) The programs are approved as necessary by the Department of Public Welfare to implement section 2(4)(vi). For the purposes of this section, shelter care shall not include institutional facilities.

Section 4.

This act shall take effect immediately, but the jurisdictional changes contained in section 2(2) and (4) [33a] shall apply only to proceedings instituted after the effective date.

Approved the 3rd day of August A.D. 1977.

TAXATION—DETERIORATED DWELLINGS—EXEMPTIONS

ACT NO. 1977–42

S.B.NO.69

An Act reenacting and amending the act of July 9, 1971 (P.L. 206, No. 34), entitled "An act authorizing local taxing authorities to provide for tax exemption for certain improvements to deteriorated dwellings; providing for an exemption schedule and other limitations," extending the act to authorize certain exemptions for improvements to deteriorating areas by the construction of new dwelling units.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The title and act of July 9, 1971 (P.L. 206, No. 34), entitled "An act authorizing local taxing authorities to provide for tax exemption for certain improvements to deteriorated dwellings; providing for an exemption schedule and other limitations," are reenacted and amended to read:

An Act authorizing local taxing authorities to provide for tax exemption for certain improvements to deteriorated dwellings and for improvement of deteriorating areas by the construction of new dwelling units; and providing for exemption schedules and other limitations.[34]

ARTICLE I. GENERAL PROVISIONS [35]

Section 101. Short Title.

This act shall be known and may be cited as the "Improvement of Deteriorating Real Property or Areas Tax Exemption Act."

Section 102. Construction.

(a) This act shall be construed to authorize local taxing authorities to exempt improvements to certain deteriorated residential property and areas thereby implementing clause (iii) of subsection (b) of section 2 of Article VIII of the Constitution of Pennsylvania.

(b) The exemptions granted under this act shall not be so considered by the State Tax Equalization Board in arriving at the market value of

33a. 11 P.S. § 50—102, subsecs. (2) and (4).

34. 72 P.S. § 4711—101 note.

35. 72 P.S. §§ 4711—101 to 4711—103.

ACT 41

Act 41 amends Act 333 of 1972, known as the Juvenile Act, in 6 major areas:

1. It defines two legal classes of children, dependent and delinquent. Those children who used to be classified as deprived will fall under the dependent definition.
2. It removes the so-called status offenders from the category of delinquent. These are the truants, the runaways, and ungovernable children who will now come under the dependent category.
3. It prohibits altogether the detaining of juveniles in county jails after December 31, 1979; and further stipulates that in no case may a child be detained unless the county jail has applied for and been approved for such juvenile detention by the Department of Public Welfare, pursuant to Chapter II, Section 28B of the Social Services Manual.
4. Dependent children cannot be placed in programs operated for delinquent children.
5. No child under the age of 10 can be declared delinquent regardless of the offens committed, and no child under the age of 12 can be committed to a State institution.
6. It provides $1.5 million for grants to counties to establish regional detention facilities. These grants are available through the Department of Public Welfare for counties with no means or need for a single county detention facility.

The passage of Act 41 makes the Commonwealth eligible to receive Federal Bayh Act funds. Each county is being asked by the Governor's Justice Commission to present a plan for its detention needs. The Department is working with the Justice Commission toward an inter-agency agreement which would make it possible to combine Act 41 funds with the Bayh Act funds to meet the needs outlined in county plans. In this way, only one plan need be submitted by the county and a more effective use of funds will be possible.

Official Advance Copy of Statute Enacted at 1976 Session

No. 143

AN ACT

SB 1025

Relating to mental health procedures; providing for the treatment and rights of mentally disabled persons, for voluntary and involuntary examination and treatment and for determinations affecting those charged with crime or under sentence.

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Section 501. Effective Date and Applicability.
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Section 503. Severability.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

ARTICLE I
General Provisions

Section 101. Short Title.—This act shall be known and may be cited as the "Mental Health Procedures Act."

Section 102. Statement of Policy.—It is the policy of the Commonwealth of Pennsylvania to seek to assure the availability of adequate treatment to persons who are mentally ill, and it is the purpose of this act to establish procedures whereby this policy can be effected. Treatment on a voluntary basis shall be preferred to involuntary treatment;

and in every case, the least restrictions consistent with adequate treatment shall be employed. Persons who are mentally retarded, senile, alcoholic, or drug dependent shall receive mental health treatment only if they are also diagnosed as mentally ill, but these conditions of themselves shall not be deemed to constitute mental illness.

Section 103. Scope of Act.—This act establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" shall include all treatment that requires full or part-time residence in a facility. For the purpose of this act, a "facility" means any mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons, whether as outpatients or inpatients.

Section 104. Provision for Treatment. Adequate treatment means a course of treatment designed and administered to alleviate a person's pain and distress and to maximize the probability of his recovery from mental illness. It shall be provided to all persons in treatment who are subject to this act. It may include inpatient treatment, partial hospitalization, or outpatient treatment. Adequate inpatient treatment shall include such accommodations, diet, heat, light, sanitary facilities, clothing, recreation, education and medical care as are necessary to maintain decent, safe and healthful living conditions. Treatment shall include diagnosis, evaluation, therapy, or rehabilitation needed to alleviate pain and distress and to facilitate the recovery of a person from mental illness and shall also include care and other services that supplement treatment and aid or promote such recovery.

Section 105. Treatment Facilities. Involuntary treatment and voluntary treatment funded in whole or in part by public moneys shall be available at a facility approved for such purposes by the county administrator (who shall be the County Mental Health and Mental Retardation Administrator of a county or counties, or his duly authorized delegate), or by the Department of Public Welfare, hereinafter cited as the "department." Approval of facilities shall be made by the appropriate authority which can be the department pursuant to regulations adopted by the department. Treatment may be ordered at the Veterans Administration or other agency of the United States upon receipt of a certificate that the person is eligible for such hospitalization or treatment and that there is available space for his care. Mental health facilities operated under the direct control of the Veterans Administration or other Federal agency are exempt from obtaining State approval. The department's standards for approval shall be at least as stringent as those of the joint commission for accreditation of hospitals and those of the Federal Government pursuant to Titles 18 and 19 of the Federal Social Security Act to the extent that the type of facility is one in which those standards are intended to apply. An exemption from the standards may be granted by the department for a

period not in excess of one year and may be renewed. Notice of each exemption and the rationale for allowing the exemption must be published pursuant to the act of July 31, 1968 (P.L.769, No.240), known as the "Commonwealth Documents Law," and shall be prominently posted at the entrance to the main office and in the reception areas of the facility.

Section 106. Persons Responsible for Formulation and Review of Treatment Plan. (a) Pursuant to sections 107 and 108 of this act, a treatment team shall formulate and review an individualized treatment plan for every person who is in treatment under this act.

(b) A treatment team must be under the direction of either a physician or a licensed clinical psychologist and may include other mental health professionals.

(c) A treatment team must be under the direction of a physician when:

(1) failure to do so would jeopardize Federal payments made on behalf of a patient, or

(2) the director of a facility requires the treatment to be under the direction of a physician.

(d) All treatment teams must include a physician and the administration of all drugs shall be controlled by the act of April 14, 1972 (P.L.211, No.64), known as "The Controlled Substance, Drug, Device and Cosmetic Act."

Section 107. Individualized Treatment Plan. Individualized treatment plan means a plan of treatment formulated for a particular person in a program appropriate to his specific needs. To the extent possible, the plan shall be made with the cooperation, understanding and consent of the person in treatment, and shall impose the least restrictive alternative consistent with affording the person adequate treatment for his condition.

Section 108. Periodic Reexamination, Review and Redisposition. (a) Reexamination and Review.--Every person who is in treatment under this act shall be examined by a treatment team and his treatment plan reviewed not less than once in every 30 days.

(b) Redisposition. On the basis of reexamination and review, the treatment team may either authorize continuation of the existing treatment plan if appropriate, formulate a new individualized treatment plan, or recommend to the director the discharge of the person. A person shall not remain in treatment or under any particular mode of treatment for longer than such treatment is necessary and appropriate to his needs.

(c) Record of Reexamination and Review. The treatment team responsible for the treatment plan shall maintain a record of each reexamination and review under this section for each person in treatment to include:

(1) a report of the reexamination, including a diagnosis and prognosis;

(2) a brief description of the treatment provided to the person during the period preceding the reexamination and the results of that treatment;

(3) a statement of the reason for discharge or for continued treatment;

(4) an individualized treatment plan for the next period, if any;

(5) a statement of the reasons that such treatment plan imposes the least restrictive alternative consistent with adequate treatment of his condition; and

(6) a certification that the adequate treatment recommended is available and will be afforded in the treatment program.

Section 109. Mental Health Review Officer.—Legal proceedings concerning extended involuntary emergency treatment under section 303(c), or court-ordered involuntary treatment under section 304, may be conducted by a judge of the court of common pleas or by a mental health review officer authorized by the court to conduct the proceedings. Mental health review officers shall be members of the bar of the Supreme Court of Pennsylvania, without restriction as to the county of their residence and where possible should be familiar with the field of mental health. They shall be appointed by the respective courts of common pleas for terms not to exceed one year, and may be reappointed to successive terms.

Section 110. Written Applications, Petitions, Statements and Certifications.—(a) All written statements pursuant to section 302(a)(2), and all applications, petitions, and certifications required under the provisions of this act shall be made subject to the penalties provided under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and shall contain a notice to that effect.

(b) All such applications, petitions, statements and certifications shall be filed with the county administrator in the county where the person was made subject to examination and treatment and such other county in the Commonwealth, if any, in which the person usually resides.

Section 111. Confidentiality of Records.—All documents concerning persons in treatment shall be kept confidential and, without the person's written consent, may not be released or their contents disclosed to anyone except:

(1) those engaged in providing treatment for the person;

(2) the county administrator, pursuant to section 110;

(3) a court in the course of legal proceedings authorized by this act; and

(4) pursuant to Federal rules, statutes and regulations governing disclosure of patient information where treatment is undertaken in a Federal agency.

In no event, however, shall privileged communications, whether written or oral, be disclosed to anyone without such written consent. This shall not restrict the collection and analysis of clinical or statistical data by the department, the county administrator or the facility so long as the use and dissemination of such data does not identify individual patients. Nothing herein shall be construed to conflict with section 8 of the act of April 14, 1972 (P.L.221, No.63), known as the "Pennsylvania Drug and Alcohol Abuse Control Act."

Section 112. Rules, Regulations and Forms.—The department shall adopt such rules, regulations and forms as may be required to effectuate the

provisions of this act. Rules and regulations adopted under the provisions of this act shall be adopted according to provisions of section 201 of the act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the "Mental Health and Mental Retardation Act of 1966," and the act of July 31, 1968 (P.L.769, No.240), known as the "Commonwealth Documents Law."

Section 113. Rights and Remedies of Persons in Treatment.—Every person who is in treatment shall be entitled to all other rights now or hereafter provided under the laws of this Commonwealth, in addition to any rights provided for in this act. Actions requesting damages, declaratory judgment, injunction, mandamus, writs of prohibition, habeas corpus, including challenges to the legality of detention or degree of restraint, and any other remedies or relief granted by law may be maintained in order to protect and effectuate the rights granted under this act.

Section 114. Immunity from Civil and Criminal Liability.—(a) In the absence of willful misconduct or gross negligence, a county administrator, a director of a facility, a physician or any other authorized person who participates in a decision that a person be examined or treated under this act, or that a person be discharged, or placed under partial hospitalization, outpatient care or leave of absence, or that the restraint upon such person be otherwise reduced, or a county administrator or other authorized person who denies an application for involuntary emergency examination and treatment, shall not be civilly or criminally liable for such decision or for any of its consequences.

(b) A judge or a mental health review officer shall not be civilly or criminally liable for any actions taken or decisions made by him pursuant to the authority conferred by this act.

Section 115. Venue and Location of Legal Proceedings.—(a) The jurisdiction of the courts of common pleas and juvenile courts conferred by Articles II and III shall be exercised initially by the court for the county in which the subject of the proceedings is or resides. Whenever involuntary treatment is ordered, jurisdiction over any subsequent proceeding shall be retained by the court in which the initial proceedings took place, but may be transferred to the county of the person's usual residence. In all cases, a judge of the court of common pleas or a mental health review officer of the county of venue may conduct legal proceedings at a facility where the person is in treatment whether or not its location is within the county.

(b) Venue for actions instituted to effectuate rights under this act shall be as now or hereafter provided by law.

ARTICLE II

Voluntary Examination and Treatment

Section 201. Persons Who May Authorize Voluntary Treatment.—Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary commitment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. A parent,

guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child. Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

Section 202. To Whom Application May be Made.—Application for voluntary examination and treatment shall be made to an approved facility or to the county administrator, Veterans Administration or other agency of the United States operating a facility for the care and treatment of mental illness. When application is made to the county administrator, he shall designate the approved facility for examination and for such treatment as may be appropriate.

Section 203. Explanation and Consent.—Before a person is accepted for voluntary inpatient treatment, an explanation shall be made to him of such treatment, including the types of treatment in which he may be involved, and any restraints or restrictions to which he may be subject, together with a statement of his rights under this act. Consent shall be given in writing upon a form adopted by the department. The consent shall include the following representations: That the person understands his treatment will involve inpatient status; that he is willing to be admitted to a designated facility for the purpose of such examination and treatment; and that he consents to such admission voluntarily, without coercion or duress; and, if applicable, that he has voluntarily agreed to remain in treatment for a specified period of no longer than 72 hours after having given written notice of his intent to withdraw from treatment. The consent shall be part of the person's record.

Section 204. Notice to Parents.—Upon the acceptance of an application for examination and treatment by a minor 14 years or over but less than 18 years of age, the director of the facility shall promptly notify the minor's parents, guardian, or person standing in loco parentis, and shall inform them of the right to be heard upon the filing of an objection. Whenever such objection is filed, a hearing shall be held within 72 hours by a judge or mental health review officer, who shall determine whether or not the voluntary treatment is in the best interest of the minor.

Section 205. Physical Examination and Formulation of Individualized Treatment Plan.—Upon acceptance of a person for voluntary examination and treatment he shall be given a physical examination. Within 72 hours after acceptance of a person an individualized treatment plan shall be formulated by a treatment team. The person shall be advised of the treatment plan, which shall become a part of his record. The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions.

Section 206. Withdrawal from Voluntary Inpatient Treatment.—(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203, he has agreed in

writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may effect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in this act shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commissioner of Mental Health or his designate.

Section 207. Transfer of Person in Voluntary Treatment.—A person who is in voluntary treatment may not be transferred from one facility to another without his written consent.

ARTICLE III
Involuntary Examination and Treatment

Section 301. Persons Who May be Subject to Involuntary Emergency Examination and Treatment.—(a) Persons Subject.—Whenever a person is severely mentally disabled and in need of immediate treatment, he may be made subject to involuntary emergency examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.

(b) Determination of Clear and Present Danger.—(1) Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated. If, however, the person has been found incompetent to be tried or has been acquitted by reason of lack of criminal responsibility on charges arising from conduct involving infliction of or attempt to inflict substantial bodily harm on another, such 30-day limitation shall not apply

so long as an application for examination and treatment is filed within 30 days after the date of such determination or verdict. In such case, a clear and present danger to others may be shown by establishing that the conduct charged in the criminal proceeding did occur, and that there is a reasonable probability that such conduct will be repeated.

(2) Clear and present danger to himself shall be shown by establishing that within the past 30 days:

(i) the person has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under this act; or

(ii) the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act; or

(iii) the person has severely mutilated himself or attempted to mutilate himself severely and that there is the reasonable probability of mutilation unless adequate treatment is afforded under this act.

Section 302. Involuntary Emergency Examination and Treatment Authorized by a Physician - Not to Exceed Seventy-two Hours. (a) Application for Examination.—Emergency examination may be undertaken at a treatment facility upon the certification of a physician stating the need for such examination; or upon a warrant issued by the county administrator authorizing such examination; or without a warrant upon application by a physician or other authorized person who has personally observed conduct showing the need for such examination.

(1) Warrant for Emergency Examination.—Upon written application by a physician or other responsible party setting forth facts constituting reasonable grounds to believe a person is severely mentally disabled and in need of immediate treatment, the county administrator may issue a warrant requiring a person authorized by him, or any peace officer, to take such person to the facility specified in the warrant.

(2) Emergency Examination Without a Warrant. -Upon personal observation of the conduct of a person constituting reasonable grounds to believe that he is severely mentally disabled and in need of immediate treatment, any physician or peace officer, or anyone authorized by the county administrator may take such person to an approved facility for an emergency examination. Upon arrival, he shall make a written statement setting forth the grounds for believing the person to be in need of such examination.

(b) Examination and Determination of Need for Emergency Treatment.—A person taken to a facility shall be examined by a physician within two hours of arrival in order to determine if the person is severely mentally disabled within the meaning of section 301 and in need of immediate treatment. If it is determined that the person is severely mentally

disabled and in need of emergency treatment, treatment shall be begun immediately. If the physician does not so find, or if at any time it appears there is no longer a need for immediate treatment, the person shall be discharged and returned to such place as he may reasonably direct. The physician shall make a record of the examination and his findings. In no event shall a person be accepted for involuntary emergency treatment if a previous application was granted for such treatment and the new application is not based on behavior occurring after the earlier application.

(c) Notification of Rights at Emergency Examination.—Upon arrival at the facility, the person shall be informed of the reasons for emergency examination and of his right to communicate immediately with others. He shall be given reasonable use of the telephone. He shall be requested to furnish the names of parties whom he may want notified of his custody and kept informed of his status. The county administrator or the director of the facility shall:

(1) give notice to such parties of the whereabouts and status of the person, how and when he may be contacted and visited, and how they may obtain information concerning him while he is in inpatient treatment; and

(2) take reasonable steps to assure that while the person is detained, the health and safety needs of any of his dependents are met, and that his personal property and the premises he occupies are secure.

(d) Duration of Emergency Examination and Treatment.—A person who is in treatment pursuant to this section shall be discharged whenever it is determined that he no longer is in need of treatment, and in any event within 72 hours, unless within such period:

(1) he is admitted to voluntary treatment pursuant to section 202 of this act; or

(2) a certification for extended involuntary emergency treatment is filed pursuant to section 303 of this act.

Section 303. Extended Involuntary Emergency Treatment Certified by a Judge or Mental Health Review Officer - Not to Exceed Twenty Days. (a) Persons Subject to Extended Involuntary Emergency Treatment. - Application for extended involuntary emergency treatment may be made for any person who is being treated pursuant to section 302 whenever the facility determines that the need for emergency treatment is likely to extend beyond 72 hours. The application shall be filed forthwith in the court of common pleas, and shall state the grounds on which extended emergency treatment is believed to be necessary. The application shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(b) Appointment of Counsel and Scheduling of Informal Hearing. Upon receiving such application, the court of common pleas shall appoint an attorney who shall represent the person unless it shall appear that the person can afford, and desires to have, private representation. Within 24 hours after the application is filed, an informal hearing shall be conducted by a judge or by a mental health review officer and, if practicable, shall be held at the facility.

(c) Informal Hearing on Extended Emergency Treatment Application.—(1) At the commencement of the informal hearing, the judge or the mental health review officer shall inform the person of the nature of the proceedings. Information relevant to whether the person is severely mentally disabled and in need of treatment shall be reviewed, including the reasons that continued involuntary treatment is considered necessary. Such explanation shall be made by a physician who examined the person and shall be in terms understandable to a layman. The person or his representative shall have the right to ask questions of the physician and of any other witnesses and to present any relevant information. At the conclusion of the review, if the judge or the review officer finds that the person is severely mentally disabled and in need of continued involuntary treatment, he shall so certify. Otherwise, he shall direct that the facility director or his designee discharge the person.

(2) A stenographic or other sufficient record of the proceedings shall be made. Such record shall be kept by the court or mental health review officer for at least one year.

(d) Contents of Certification.—A certification for extended involuntary treatment shall be made in writing upon a form adopted by the department and shall include:

(1) findings by the judge or mental health review officer as to the reasons that extended involuntary emergency treatment is necessary;

(2) a description of the treatment to be provided together with an explanation of the adequacy and appropriateness of such treatment, based upon the information received at the hearing;

(3) any documents required by the provisions of section 302;

(4) the application as filed pursuant to section 303(a);

(5) a statement that the person is represented by counsel; and

(6) an explanation of the effect of the certification, the person's right to petition the court for release under subsection (g), and the continuing right to be represented by counsel.

(e) Filing and Service.—The certification shall be filed with the director of the facility and a copy served on the person, such other parties as the person requested to be notified pursuant to section 302(c), and on counsel.

(f) Effect of Certification.—Upon the filing and service of a certification for extended involuntary emergency treatment, the person may be given treatment in an approved facility for a period not to exceed 20 days.

(g) Petition to Common Pleas Court.—In all cases in which the hearing was conducted by a mental health review officer, a person made subject to treatment pursuant to this section shall have the right to petition the court of common pleas for review of the certification. A hearing shall be held within 72 hours after the petition is filed unless a continuance is requested by the person's counsel. The hearing shall include a review of the certification and such evidence as the court may receive or require. If the

court determines that further involuntary treatment is necessary and that the procedures prescribed by this act have been followed, it shall deny the petition. Otherwise, the person shall be discharged.

(h) Duration of Extended Involuntary Emergency Treatment. – Whenever a person is no longer severely mentally disabled or in need of immediate treatment and, in any event, within 20 days after the filing of the certification, he shall be discharged, unless within such period:

(1) he is admitted to voluntary treatment pursuant to section 202; or

(2) the court orders involuntary treatment pursuant to section 304.

Section 304. Court-ordered Involuntary Treatment Not to Exceed Ninety Days.—(a) Persons for Whom Application May be Made.—(1) A person who is severely mentally disabled and in need of treatment, as defined in section 301(a), may be made subject to court-ordered involuntary treatment upon a determination of clear and present danger under section 301(b)(1) (serious bodily harm to others), or section 301(b)(2)(i) (inability to care for himself, creating a danger of death or serious harm to himself), or 301(b)(2)(ii) (attempted suicide), or 301(b)(2)(iii) (self-mutilation).

(2) Where a petition is filed for a person already subject to involuntary treatment, it shall be sufficient to represent, and upon hearing to reestablish, that the conduct originally required by section 301 in fact occurred, and that his condition continues to evidence a clear and present danger to himself or others. In such event, it shall not be necessary to show the reoccurrence of dangerous conduct, either harmful or debilitating, within the past 30 days.

(b) Procedures for Initiating Court-ordered Involuntary Treatment for Persons Already Subject to Involuntary Treatment.—(1) Petition for court-ordered involuntary treatment for persons already subject to treatment under sections 303 and 305 may be made by the county administrator to the court of common pleas.

(2) The petition shall be in writing upon a form adopted by the department and shall include a statement of the facts constituting reasonable grounds to believe that the person is severely mentally disabled and in need of treatment. The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person. It shall also state that the person has been given the information required by subsection (b)(3) and shall include copies of all documents relating to examination and treatment of the person which are required under this act.

(3) Upon the filing of the petition the county administrator shall serve a copy on the person, his attorney, and those designated to be kept informed, as provided in section 302(c), including an explanation of the nature of the proceedings, the person's right to an attorney and the services of an expert in the field of mental health, as provided by subsection (d).

(4) A hearing on the petition shall be held in all cases, not more than five days after the filing of the petition.

(5) Treatment shall be permitted to be maintained pending the determination of the petition.

(c) Procedures for Initiating Court-ordered Involuntary Treatment for Persons not in Involuntary Treatment.—(1) Any responsible party may file a petition in the court of common pleas requesting court-ordered involuntary treatment for any person not already in involuntary treatment for whom application could be made under subsection (a).

(2) The petition shall be in writing upon a form adopted by the department and shall set forth facts constituting reasonable grounds to believe that the person is within the criteria for court-ordered treatment set forth in subsection (a). The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(3) Upon a determination that the petition sets forth such reasonable cause, the court shall appoint an attorney to represent the person and set a date for the hearing as soon as practicable. The attorney shall represent the person unless it shall appear that he can afford, and desires to have, private representation.

(4) The court, by summons, shall direct the person to appear for a hearing. The court may issue a warrant directing a person authorized by the county administrator or a peace officer to bring such person before the court at the time of the hearing if there are reasonable grounds to believe that the person will not appear voluntarily. A copy of the petition shall be served on such person at least three days before the hearing together with a notice advising him that an attorney has been appointed who shall represent him unless he obtains an attorney himself, that he has a right to be assisted in the proceedings by an expert in the field of mental health, and that he may request or be made subject to psychiatric examination under subsection (c)(5).

(5) Upon motion of either the petitioner or the person, or upon its own motion, the court may order the person to be examined by a psychiatrist appointed by the court. Such examination shall be conducted on an outpatient basis, and the person shall have the right to have counsel present. A report of the examination shall be given to the court and counsel at least 48 hours prior to the hearing.

(6) Involuntary treatment shall not be authorized during the pendency of a petition except in accordance with section 302 or section 303.

(d) Professional Assistance.—A person with respect to whom a hearing has been ordered under this section shall have and be informed of a right to employ a physician, clinical psychologist or other expert in mental health of his choice to assist him in connection with the hearing and to testify on his behalf. If the person cannot afford to engage such a professional, the court shall, on application, allow a reasonable fee for such purpose. The fee shall be a charge against the mental health and mental retardation program of the locality.

(e) Hearings on Petition for Court-ordered Involuntary Treatment.—A hearing on a petition for court-ordered involuntary treatment shall be conducted according to the following:

(1) The person shall have the right to counsel and to the assistance of an expert in mental health.

(2) The person shall not be called as a witness without his consent.

(3) The person shall have the right to confront and cross-examine all witnesses and to present evidence in his own behalf.

(4) The hearing shall be public unless it is requested to be private by the person or his counsel.

(5) A stenographic or other sufficient record shall be made, which shall be impounded by the court and may be obtained or examined only upon the request of the person or his counsel or by order of the court on good cause shown.

(6) The hearing shall be conducted by a judge or by a mental health review officer and may be held at a location other than a courthouse when doing so appears to be in the best interest of the person.

(7) A decision shall be rendered within 48 hours after the close of evidence.

(f) Determination and Order.—Upon a finding by clear and convincing evidence that the person is severely mentally disabled and in need of treatment and subject to subsection (a), an order shall be entered directing treatment of the person in an approved facility as an inpatient or an outpatient. Inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives. Investigation of treatment alternatives shall include consideration of the person's relationship to his community and family, his employment possibilities, all available community resources, and guardianship services. An order for inpatient treatment shall include findings on this issue.

(g) Duration of Court-ordered Involuntary Treatment.—(1) A person may be made subject to court-ordered involuntary treatment under this section for a period not to exceed 90 days, excepting only that: Persons may be made subject to court-ordered involuntary treatment under this section for a period not to exceed one year if:

(i) severe mental disability is based on acts giving rise to the following charges under the Pennsylvania Crimes Code: murder (§ 2502); voluntary manslaughter (§ 2503); aggravated assault (§ 2702); kidnapping (§ 2901); rape (§ 3121(1) and (2)); involuntary deviate sexual intercourse (§ 3123(1) and (2)); and

(ii) a finding of incompetency to be tried or a verdict of acquittal because of lack of criminal responsibility has been entered.

(2) If at any time the director of a facility concludes that the person is not severely mentally disabled or in need of treatment pursuant to subsection (a), he shall discharge the person.

Section 305. Additional Periods of Court-ordered Involuntary Treatment.—At the expiration of a period of court-ordered involuntary

treatment under section 304(g), the court may order treatment for an additional period upon the application of the county administrator or the director of the facility in which the person is receiving treatment. Such order shall be entered upon hearing on findings as required by sections 304(a) and (b), and the further finding of a need for continuing involuntary treatment as shown by conduct during the person's most recent period of court-ordered treatment. A person found dangerous to himself under section 301(b)(2)(i),(ii) or (iii) shall be subject to an additional period of involuntary full-time inpatient treatment only if he has first been released to a less restrictive alternative. This limitation shall not apply where, upon application made by the county administrator or facility director, it is determined by a judge or mental health review officer that such release would not be in the person's best interest.

Section 306. Transfer of Persons in Involuntary Treatment.—Person in involuntary treatment pursuant to this act may be transferred to any approved facility. Whenever such transfer will constitute a greater restraint, it shall not take place unless, upon hearing, a judge or mental health review officer finds it to be necessary and appropriate.

ARTICLE IV
Determinations Affecting Those Charged With Crime, or Under Sentence

Section 401. Examination and Treatment of a Person Charged with Crime or Serving Sentence.—(a) Examination and Treatment to be Pursuant to Civil Provisions.—Whenever a person who is charged with crime, or who is undergoing sentence, is or becomes severely mentally disabled, proceedings may be instituted for examination and treatment under the civil provisions of this act in the same manner as if he were not so charged or sentenced. Proceedings under this section shall not be initiated for examination and treatment at Veterans Administration facilities if such examination and treatment requires the preparation of competency reports and/or the facility is required to maintain custody and control over the person. Such proceedings, however, shall not affect the conditions of security required by his criminal detention or incarceration.

(b) Status in Involuntary Treatment.—Whenever a person who is detained on criminal charges or is incarcerated is made subject to inpatient examination or treatment, he shall be transferred, for this purpose, to a mental health facility. Transfer may be made to a Veterans Administration facility provided that neither custody nor control are required in addition to examination and treatment. Such individuals transferred to the Veterans Administration are not subject to return by the Federal agency to the authority entitled to have them in custody. During such period, provisions for his security shall continue to be enforced, unless in the interim a pretrial release is effected, or the term of imprisonment expires or is terminated, or it is otherwise ordered by the court having jurisdiction over his criminal status. Upon discharge from treatment, a person who is or

remains subject to a detainer or sentence shall be returned to the authority entitled to have him in custody. The period of involuntary treatment shall be credited as time served on account of any sentence to be imposed on pending charges or any unexpired term of imprisonment.

(c) Persons Subject to the Juvenile Act.—As to any person who is subject to a petition or who has been committed under the Juvenile Act, the civil provisions of this act applicable to children of his age shall apply to all proceedings for his examination and treatment. If such a person is in detention or is committed, the court having jurisdiction under the Juvenile Act shall determine whether such security conditions shall continue to be enforced during any period of involuntary treatment and to whom the person should be released thereafter.

Section 402. Incompetence to Proceed on Criminal Charges and Lack of Criminal Responsibility as Defense.—(a) Definition of Incompetency.—Whenever a person who has been charged with a crime is found to be substantially unable to understand the nature or object of the proceedings against him or to participate and assist in his defense, he shall be deemed incompetent to be tried, convicted or sentenced so long as such incapacity continues.

(b) Involuntary Treatment of Persons Found Incompetent to Stand Trial Who are Not Mentally Disabled.—Notwithstanding the provisions of Article III of this act, a court may order involuntary treatment of a person found incompetent to stand trial but who is not severely mentally disabled, such involuntary treatment not to exceed a specific period of 30 days. Involuntary treatment pursuant to this subsection may be ordered only if the court is reasonably certain that the involuntary treatment will provide the defendant with the capacity to stand trial. The court may order outpatient treatment, partial hospitalization or inpatient treatment.

(c) Application for Incompetency Examination.—Application to the court for an order directing an incompetency examination may be presented by an attorney for the Commonwealth, a person charged with a crime, his counsel, or the warden or other official in charge of the institution or place in which he is detained. A person charged with crime shall be represented either by counsel of his selection or by court-appointed counsel.

(d) Hearing; When Required.—The court, either on application or on its own motion, may order an incompetency examination at any stage in the proceedings and may do so without a hearing unless the examination is objected to by the person charged with a crime or by his counsel. In such event, an examination shall be ordered only after determination upon a hearing that there is a prima facie question of incompetency.

(e) Conduct of Examination; Report.—When ordered by the court, an incompetency examination shall take place under the following conditions:

(1) It shall be conducted as an outpatient examination unless an inpatient examination is, or has been, authorized under another provision of this act.

(2) It shall be conducted by at least one psychiatrist and may relate both to competency to proceed and to criminal responsibility for the crime charged.

(3) The person shall be entitled to have counsel present with him and shall not be required to answer any questions or to perform tests unless he has moved for or agreed to the examination. Nothing said or done by such person during the examination may be used as evidence against him in any criminal proceedings on any issue other than that of his mental condition.

(4) A report shall be submitted to the court and to counsel and shall contain a description of the examination, which shall include:

(i) diagnosis of the person's mental condition;

(ii) an opinion as to his capacity to understand the nature and object of the criminal proceedings against him and to assist in his defense;

(iii) when so requested, an opinion as to his mental condition in relation to the standards for criminal responsibility as then provided by law if it appears that the facts concerning his mental condition may also be relevant to the question of legal responsibility; and

(iv) when so requested, an opinion as to whether he had the capacity to have a particular state of mind, where such state of mind is a required element of the criminal charge.

(f) Experts. - The court may allow a psychiatrist retained by the defendant or the prosecution to witness and participate in the examination. Whenever a defendant who is financially unable to retain such expert has a substantial objection to the conclusions reached by the court-appointed psychiatrist, the court shall allow reasonable compensation for the employment of a psychiatrist of his selection, which amount shall be chargeable against the mental health and mental retardation program of the locality.

(g) Time Limit on Determination. The determination of the competency of a person who is detained under a criminal charge shall be rendered by the court within 20 days after the receipt of the report of examination unless the hearing was continued at the person's request.

Section 403. Hearing and Determination of Incompetency to Proceed; Stay of Proceedings; Dismissal of Charges. (a) Competency Determination and Burden of Proof. - The moving party shall have the burden of establishing incompetency to proceed by clear and convincing evidence. The determination shall be made by the court.

(b) Effect as Stay - Exception. A determination of incompetency to proceed shall effect a stay of the prosecution for so long as such incapacity persists, excepting that any legal objections suitable for determination prior to trial and without the personal participation of the person charged may be raised and decided in the interim.

(c) Defendant's Right to Counsel; Reexamination. A person who is determined to be incompetent to proceed shall have a continuing right to counsel so long as the criminal charges are pending. Following such determination, the person charged shall be reexamined not less than every

60 days by a psychiatrist appointed by the court and a report of reexamination shall be submitted to the court and to counsel.

(d) Effect on Criminal Detention. Whenever a person who has been charged with a crime has been determined to be incompetent to proceed, he shall not for that reason alone be denied pretrial release. Nor shall he in any event be detained on the criminal charge longer than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If the court determines there is no such probability, it shall discharge the person. Otherwise, he may continue to be criminally detained so long as such probability exists but in no event longer than the period of time specified in subsection (f)

(e) Resumption of Proceedings or Dismissal. When the court, on its own motion or upon the application of the attorney for the Commonwealth or counsel for the defendant, determines that such person has regained his competence to proceed, the proceedings shall be resumed. If the court is of the opinion that by reason of the passage of time and its effect upon the criminal proceedings it would be unjust to resume the prosecution, the court may dismiss the charge and order the person discharged

(f) Stay of Proceedings. In no instance shall the proceedings be stayed for a period in excess of the maximum sentence that may be imposed for the crime or crimes charged, or five years, whichever is less.

Section 404. Hearing and Determination of Criminal Responsibility; Bifurcated Trial. (a) Criminal Responsibility Determination by Court. At a hearing under section 403 of this act the court may, in its discretion, also hear evidence on whether the person was criminally responsible for the commission of the crime charged. It shall do so in accordance with the rules governing the consideration and determination of the same issue at criminal trial. If the person is found to have lacked criminal responsibility, an acquittal shall be entered. If the person is not so acquitted, he may raise the defense at such time as he may be tried.

(b) Opinion Evidence on Mental Condition. At a hearing under section 403 or upon trial, a psychiatrist appointed by the court may be called as a witness by the attorney for the Commonwealth or by the defendant and each party may also summon any other psychiatrist or other expert to testify.

(c) Bifurcation of Issues on Trial. Upon trial, the court, in the interest of justice, may direct that the issue of criminal responsibility be heard and determined separately from the other issues in the case and, in a trial by jury, that the issue of criminal responsibility be submitted to a separate jury. Upon a request for bifurcation, the court shall consider the substantiality of the defense of lack of responsibility and its effect upon other defenses, and the probability of a fair trial.

Section 405. Examination of Person Charged with Crime as Aid in Sentencing. Examination Before Imposition of Sentence. Whenever a

person who has been criminally charged is to be sentenced, the court may defer sentence and order him to be examined for mental illness to aid it in the determination of disposition. This action may be taken on the court's initiative or on the application of the attorney for the Commonwealth, the person charged, his counsel, or any other person acting in his interest. If at the time of sentencing the person is not in detention, examination shall be on an outpatient basis unless inpatient examination for this purpose is ordered pursuant to the civil commitment provisions of Article III.

Section 406. Civil Procedure for Court-ordered Involuntary Treatment Following a Determination of Incompetency, or Acquittal by Reason of Lack of Criminal Responsibility or in Conjunction with Sentencing.—Upon a finding of incompetency to stand trial under section 403, after an acquittal by reason of lack of responsibility under section 404, or following an examination in aid of sentencing under section 405, the attorney for the Commonwealth, on his own or acting at the direction of the court, the defendant, his counsel, the county administrator, or any other interested party may petition the same court for an order directing involuntary treatment under section 304.

ARTICLE V
Effective Date, Applicability, Repeals and Severability

Section 501. Effective Date and Applicability.—This act shall take effect 60 days after its enactment and shall thereupon apply immediately to all persons receiving voluntary treatment. As to all persons who were made subject to involuntary treatment prior to the effective date, it shall become applicable 180 days thereafter.

Section 502. Repeals.—(a) The definition of "mental disability" in section 102, and sections 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 416, 418, 419, 420 and 426, act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the "Mental Health and Mental Retardation Act of 1966," are hereby repealed, except in so far as they relate to mental retardation or to persons who are mentally retarded.

Section 29 of the act of December 6, 1972 (P.L.1464, No.333), known as the "Juvenile Act," except so far as it relates to mental retardation or to persons who are mentally retarded, is hereby repealed.

(b) All acts and parts of acts are repealed in so far as they are inconsistent herewith.

Section 503. Severability.—If any provision of this act including, but not limited to, any provision relating to children or the application thereof including but not limited to an application thereof to a child is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provisions or application and to this end the provisions of this act are declared severable.

APPROVED—The 9th day of July, A. D. 1976.

MILTON J. SHAPP

Number of Persons

Treatment of Mentally Ill Persons in Accordance With the Mental Health Procedures Act of 1976

The Department of Public Welfare, under the authority of the Mental Health Procedures Act, act of July 9, 1976, P. L. —, (No. 143), Section 112; the Mental Health Mental Retardation Act of 1966, act of October 20, 1966 (3rd Sp. Sess. P. L. 96 (No. 6), Section 201; and the Public Welfare Code, act of June 13, 1967, Public Law 31 (No. 21) hereby adopts regulations implementing the Mental Health Procedures Act of 1976, Act of July 9, 1976, P. L. — (No. 143). This Act, together with these regulations, outline the policies and procedures concerning all involuntary treatment, all inpatient voluntary treatment, and outpatient voluntary treatment if funded in whole or in part by public monies. The Act mandates numerous and significant departures from existing policies and procedures, dictated in part by court decisions defining the constitutional rights of mentally ill persons.

These regulations are intended as a comprehensive explanation of the Act. For this reason, many provisions of the Act were incorporated without change into the regulations, particularly those sections dealing with various commitment procedures. While some persons objected to this redundancy and its consequent length, the Department hopes that the result is an effective operational guide for those persons involved in the mental health delivery system.

Proposed regulations were promulgated for comment August 7, 1976, *Pennsylvania Bulletin*, Vol. 6, No. 31. A public hearing was held August 20, 1976, numerous meetings were h with county administrators and var providers of mental health services, a great number of written comme were received. Among those gro submitting comments on the prop regulations were representatives county government, hospital admi trators, mental health practition staff members of state and private m tal health facilities, various departm and agencies of the Commonwealth, torneys whose practice includes a cating the rights of the mentally ill various private individuals and gro concerned with the treatment of m tally ill persons. All of their comm were considered by the Department the process of revising the proposed r ulations, and many provided valu insight on their impact upon the clin setting.

Many of the comments were directed to portions of the proposed regulations incorporating provisions of the Act. The Department was therefore unable to adopt these suggestions. Many persons criticized as unduly cumbersome and complicated the procedures for involuntary commitment. At the same time, proponents of patients' rights argued that these procedures did not go far enough in protecting the rights of the mentally ill. The Department recognizes the burdens placed on the mental health system by these procedures, but emphasizes that these procedures are mandated by the Act and exist as a matter of statutory and constitutional right.

Additionally, many comments criticized the requirement that the County Administrator be notified of specified actions. Again, these requirements were mandated by the Act.

Many comments complained that the procedures specified in the regulations were unclear and major effort has been made to meet this criticism. Other comments concerned the issue of confidentiality and privilege, the nature of the informal hearing under Section 303(c) of the Act, patients' rights, and the procedures for treatment of those persons awaiting trial or under sentence under Article IV of the Act, and others as indicated below.

Numerous changes have been made in the proposed regulations, many of them organizational in nature. The definition section has been revised by incorporating some definitions directly into the appropriate substantive section; some changes in the oppesite directions have also been made. Throughout the regulations, paragraphs have been subdivided, consolidated, and rearranged in sequence in an effort to improve their clarity. New sections on the forms required under the Act and on Agencies of the United States have been added, as has material on those laws and regulations repealed by the Act.

References to forms required under the regulations have been added throughout, and mandated forms issued by the Department were included in Appendix A.

Appendix B, a Reimbursement Schedule for Act 143 Expenditures was also added to the regulations. Time limitations however did not allow the Department to comprehensively list the items ultimately to be in this schedule. The Department at this time adopts the schedule in its incomplete form, but intends to publish a revised schedule in the future.

In response to numerous requests various sections have been rewritten to emphasize that the time limits specified are firm deadlines, not subject to extension to allow for non work days or for any other reason.

A completely new numbering system, designed to fit properly into the structure of the Mental Health Manual has also been adopted.

Major areas of substantive change include the following:

Section 7100.1.3.: The "Scope of the Regulations" has been broadened to spell out the Department's approval power over facilities providing voluntary outpatient treatment if the treatment is funded in whole or in part by public monies. The Department believes that Section 105 of the Act requires this revision. A corresponding change has been made in Section 7100.1.5.1. dealing specifically with the Department's approval power. The scope of the rights and procedures required by the Act and the regulations, remains limited to involuntary treatment and voluntary inpatient treatment.

Section 7100.1.6.2.: The "Responsibility for Formulation of Plan and Treatment" was revised to narrow significantly those instances in which the treatment team need be under the direction of a physician. Many persons commented that the Act did not require that a physician direct the team for all inpatient services, and the requirement has been deleted. The specific reference to Titles XVIII and XIX of the Social Security Act was also deleted.

Section 7100.1.7.: "Confidentiality" provisions were revised to broaden the patient's access to his or her records. The grounds for limiting a patient's access for medical reasons were narrowed, as was the facility's power to accept information upon an agreement not to identify the informant. This section was also revised to indicate the relationship between this Act and the Pennsylvania Drug and Alcohol Abuse Control Act, regarding disclosure of information.

Section 7100.1.10.: "Rights and Remedies of Person in Treatment" were revised to conform with the provisions of the Patients Bill of Rights included in the Patients' Rights Regulations proposed by the Department and promulgated for comment August 7, 1976, *Pennsylvania Bulletin*, Vol. 6, No. 34, and to clarify the rights guaranteed to all persons receiving treatment under the Act and these regulations.

Section 7100.2.6.: "Withdrawal From Voluntary Treatment" was revised to require a more detailed medical finding, absent severe mental disability, before a patient may be detained after giving notice of intent to withdraw from treatment. Additionally, procedures for detaining the patient were further detailed.

Section 7100.2.7.2.: "Non-Acceptance of Treatment Plan" was revised to require a consideration of reasonable alternative treatment plans prior to discharge.

Section 7100.3.3.5.: "Involuntary Emergency Treatment" has been revised to indicate that, in the absence of informed consent, such treatment is limited to responding to the emer and to performing other essential ment.

Section 7100.3.4.3.: "Informal ing" has been extensively revise specify the procedures to be follow seeking extended emergency exam tion and treatment. This section emphasizes that evidence must be sented on the two distinct issues dressed at the informal hearing: conduct upon which a finding of me disability may be based; and the rea why continued treatment is neces The procedural rights granted the tient have been clearly defined. patient's right to cross-examine physician and any other person wi evidence has been introduced into record, and the right to present relev information on his or her own be have been specified.

Section 7100.3.5.2.: "Initiatio Court Ordered Involuntary Treatm for Persons Already Subject to Invo tary Treatment" was revised to req that the petition be filed not less t five (5) days prior to the expiration of current period of involuntary treatm This change is intended to empha the requirement that the facility ac extend the court order directing invo tary treatment prior to the termunatio existing order.

The Department of Public Welf hereby orders:

A. The regulations hereby adopted set forth in Annex A to this order.

B. The Secretary of the Departmen Public Welfare shall submit this Or and Annex A hereto to the Departmen Justice for approval as to legality as quired by law.

C. The Secretary of the Departmen Public Welfare shall duly certify t Order and Annex A hereto and dep same in the Legislative Refere Bureau as required by law.

D. This Order shall take effect S tember 7, 1976.

FRANK S. BEAL
Secretary of Public Welf

Annex A

CHAPTER 7100 ADMISSION AND COMMITMENT PROCEDURES

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§ 7100.1. General provisions.

§ 7100.1.1. Legal base.

The Department of Public Welfare adopts these regulations pursuant to the authority of the Mental Health Procedures Act, Act of July 9, 1976, P. L.—, (No. 143), § 112, The Mental Health and Mental Retardation Act of 1966, act of October 20, 1966 (Third Sp. Session) P. L. 96, (No. 6), § 201, and the Public Welfare Code, act of June 13, 1967, P. L. 31, (No. 21).

§ 7100.1.2. Definitions.

The following words and terms as used in these regulations shall mean:

"Act" means the Mental Health Procedures Act of 1976, July 9, 1976, P. L. —, No. 143.

"Adequate treatment" means a course of treatment designed and administered to alleviate a person's pain and distress and to maximize the probability of recovery from mental illness. It may include inpatient treatment, partial hospitalization, or outpatient treatment. Adequate inpatient treatment shall include such accommodations: diet, heat, light, sanitary facilities, clothing, recreation, education and medical care as are necessary to maintain decent, safe and healthful living conditions.

"Administrator" means the person appointed to carry out the duties specified in section 305 of the Mental Health Mental Retardation Act of 1966, or his or her designee.

"Agency of the United States" means any instrumentality of the United States, its departments, and any agencies such and shall include the Veterans Administration.

"Approved Facility" means a facility which meets the standards for approval established by the Department in the and other applicable regulations unless an exemption in writing has been granted by the Department.

"Attorney for the Commonwealth" means district attorney, the Attorney General, or any attorney representing the interests of the Commonwealth.

"Clinical psychologist" means a person who by years of study, training and experience has achieved professional recognition and standing in the field of clinical psychology.

"County program" means a mental health and mental retardation program established by a county, or a first class city, or two or more counties acting in concert and includes a complex of services providing a continuum of care in the community for the mentally disabled.

"Department" means the Department of Public Welfare.

"Designated facility" means a State operated facility named by the Department, or other facility named by the Administrator, for certain purposes or as a place of reception.

"Director" means the administrative head of a facility and includes Superintendents or his or her designee.

"Director of a treatment team" means a physician or licensed clinical psychologist designated by the facility director to assure that each patient receives treatment in accordance with these regulations and that the facility's treatment responsibilities to the patient, as defined in these regulations, the Mental Health and Mental Retardation Act of 1966, and this Act are discharged. The director of the treatment team is responsible for the implementation and review of the individualized treatment plan and for the coordination of service delivery from other service providers. The director of the treatment team is responsible for insuring that the unique skills and knowledge of each team member are utilized and that the person in treatment is encouraged to become increasingly involved in the treatment planning process.

"Expert in the field of Mental Health" means a mental health professional whose training and experience clearly exceeds the minimal standards required for recognition as a professional in his or her discipline, and whose broad-based skills and knowledge in his or her specific areas of speciality are recognized by the members of his or her profession to be at the highest level.

"*Facility*" means any mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care of rehabilitation of mentally ill persons, whether as outpatients or inpatients.

"*Inpatient treatment*" means any and all treatment that requires full or part time residence in a facility and may include partial hospitalization.

"*Involuntary Emergency Examination*" means the physical and mental evaluation by a physician of an individual taken to a facility in accordance with Section 7100.3.3. of these regulations.

"*Involuntary Emergency Treatment*" means the treatment provided to an individual taken to a facility in accordance with Section 7100,3.3. of these regulations and in the absence of informed consent by the individual shall be limited to that treatment which is necessary to protect the life and health of the individual or to control behavior by the individual which is likely to result in physical injury to others.

"*Licensed Clinical Psychologist*" means a psychologist" licensed in accordance with Act of March 23, 1972, P. L. (No. 52) (63 P. S. § 1201 *et seq.*) who holds a doctoral degree from an accredited university and is duly trained and experienced in the delivery of direct preventitive, assessment and therapeutic intervention services to individuals whose growth, adjustment, or functioning is actually impaired or is demonstrably at risk of impairment.

"*Mental Health Review Officer*" means an individual authorized by a court of common pleas to conduct legal proceedings in accordance with the Act and these regulations. Such individual shall be a member of the bar of the Supreme Court of Pennsylvania, without restriction as to the county of his or her residence, appointed by a court of common pleas for a term not to exceed one year, and may be reappointed to successive terms. Such individual, where possible, shall be familiar with the field of mental health.

"*Mental Health Professional*" means those persons who by years of study, training and experience have achieved professional recognition and standing as defined by their respective mental health disciplines, including, but not limited to, psychiatry, social work, psychology, nursing, occupational therapy and recreational therapy and who have obtained licensure or certification if applicable.

"*Mental illness*" means those disorders listed in the applicable APA Diagnostic Manual, provided, however, that mental retardation, alcoholism, drug dependence and senility do not constitute mental illness in and of themselves. Persons suffering from these disorders may, however, also be mentally ill.

"*Outpatient treatment*" means any and all treatment rendered at a facility which does not require full or part time residence at the facility and may include partial hospitalization.

"*Partial hospitalization*" means inpatient or outpatient treatment rendered to an individual admitted or committed to a facility for some portion of one or more 24 hour periods.

"*Peace officer*" means any person who by virtue of his or her office of public employment is vested by law with a duty to maintain public order or to make arrest for offenses, whether that duty extends to all offenses or is limited to specific offenses, or any person on active State duty pursuant to Section 311 of the act of May 27, 1949, P. L. 1903, known as the "The Military Code of 1949."

"*Physician*" means a physician licensed to practice in Pennsylvania and shall include a psychiatrist.

"*Preliminary evaluation*" means the initial assessment or evaluation of the physical and mental condition of an individual requesting voluntary treatment in accordance with Section 7100.2.1. of these regulations. The person's physical and mental condition may be determined without substantiation by formal testing procedure and includes an assessment of the person's specific physical, psychological, developmental, familial, educational, social and enviromental needs to determine the adequacy of the person's logic, judgment, and emotional controls to responsibly meet his or her needs.

"*Privileged communications*" means any communication made in confidence within the scope of a confidential relationship recognized by statute or common law. It shall include confidential communications made by the person to his or her spouse, attorney, physician, psychologist, or clergyman.

"*Psychiatrist*" means a physician who by years of study, training and experience has achieved professional recognition and standing in the field of psychiatry.

"*Treatment*" means diagnosis, evaluation, therapy, or rehabilitation needed to alleviate pain and distress and to facilitate the recovery of a person from mental illness and includes care and other services that aid or promote such recovery when specified in the treatment plan.

"*Treatment plan*" means an individualized plan of treatment formulated for a particular person in a program appropriate to his or her specific needs, and to the extent possible, made with the cooperation, understanding and consent of the person in treatment, and imposing the least restrictive alternative consistent with affording the person adequate

treatment for his or her condition forms developed by facility and appr by Department.

"*Treatment team*" means an inte ciplinary team of at least three per appointed by the facility director. posed of mental health professionals others. At least one member of the shall be physician. The treatment shall formulate and review an i vidualized treatment plan for every son who is in treatment under this The treatment team shall consult appropriate persons regarding the in sion in the treatment plan of spe modalities not within the training experience of the members of the tr ment team.

§ 7100.1.3. Scope of regulations.

A. These regulations and the Act tablish rights and procedures for al voluntary treatment of mentally ill sons, whether inpatient or outpati and for all voluntary inpatient treatm of persons with mental illness.

B. These regulations and the Act tablish approval standards for facilities providing involuntary inpat or outpatient treatment or voluntary patient treatment and all facilities viding voluntary outpatient treatmer such voluntary outpatient treatmen funded in whole or in part by pu monies.

§ 7100.1.4. Statement of policy.

A. The Act establishes new pro dures for the treatment of mentally persons. The Act and the Mental Hea and Mental Retardation Act of 1966, amended, work concurrently to prov the Commonwealth's policy on men health services.

It is the policy of the Commonwealth seek to assure the availability adequate treatment to persons who mentally ill, and it is the purpose of the regulations to establish and specify p cedures whereby this policy can be fected. Treatment on a voluntary ba shall be preferred to involuntary tre ment; and in every case, the least strictions consistent with adequa treatment shall be employed. Treatme provided in an individual's own comm nity or as close as possible to his or h own home shall be preferred. Perso who are mentally retarded, senile, coholic, or drug dependent shall rece mental health treatment only if they a also diagnosed as mentally ill, but the conditions of themselves shall not deemed to constitute mental illness.

B. The Act repeals the following se tions of existing law:

1. The definition of "mentally disab lity" in Section 102, and Sections 40 402, 403, 404, 405, 406, 407, 408, 4 410, 411, 412, 413, 416, 418, 419, 4 and 426 of the Mental Health and Ment Retardation Act of 1966, except insof

as they relate to mental retardation or to persons who are mentally retarded.

2. Section 29 of the Juvenile Act of 1972, (P. L. 1464, No. 333) except insofar as it relates to mental retardation or to persons who are mentally retarded.

C. All other Acts and parts of Acts, and all other regulations and parts of regulations, shall be read subject to the policy and provisions of the Act and these regulations and are repealed to the extent they are inconsistent with these policies and provisions.

§ 7100.1.5. Treatment facilities.

§ 7100.1.5.1. Approval.

A. All facilities providing involuntary treatment or voluntary inpatient treatment and all facilities providing voluntary outpatient treatment, if such voluntary outpatient treatment is funded in whole or in part by public monies, shall be approved by the Department.

B. Each facility subject to Departmental approval in accordance with paragraph A.1. of this section shall, as of March 1, 1977, meet the standards required for accreditation by the Joint Commission for Accreditation of Hospitals (JCAH) and the standards required for participation in Title XVIII and XIX of the Social Security Act to the extent that such standards apply to the facility.

C. Facilities operated under the direct control of the Veterans' Administration or other Federal agency shall not be subject to obtaining approval by the Department.

§ 7100.1.5.2. Exemption.

A. An exemption from approval standards may be granted by the Department for a period not to exceed one year, but may be renewed. Notice of the exemption and the reasons must be published pursuant to the Commonwealth Documents Law, act of July 31, 1968, P. L. 769 (No. 240) (45 P. S. § 1101, *et seq.*) and shall be prominently posted at the entrance to the Main Office and in the reception areas of the facility.

B. Facilities requesting such an exemption shall submit a written request to the Deputy Secretary for Mental Health within 120 days of the effective date of these regulations. Reasons for the exemption request shall be stated, and shall show the inability of the facility to meet the standards, and compelling reasons why the exemption should be granted. A copy of such request shall be prominently posted at the entrance to the Main Office and in the reception areas of the facility.

§ 7100.1.6. Treatment.

§ 7100.1.6.1. Responsibility for formulation of plan and treatment.

A. A treatment team shall formulate and review an individualized treatment plan for every person who is in treatment.

B. The team shall assure that staff trained and experienced in the use of the modalities proposed in the treatment plan shall participate in its development, implementation, and review.

C. The team shall be under the direction of either a physician or a licensed clinical psychologist.

D. A treatment team shall be under the direction of a physician:

1. when failure to do so would jeopardize federal payments made on behalf of a patient; or

2. when the director of the facility requires same.

E. Though a treatment team may be under the direction of a physician, specific treatment modalities may be under the direction of other mental health professionals.

F. All treatment teams shall include a physician who shall be responsible for the administration of all drugs.

§ 7100.1.6.2. Contents of Treatment Plan.

A. A comprehensive individualized plan of treatment shall:

1. be formulated with the consultation of the patient, his or her family, or legal guardian to the extent feasible.

2. be based upon diagnostic evaluation which includes examination of the medical, psychological, social, behavorial, educational, and developmental aspects of the patient's situation.

3. set forth treatment objectives and prescribe an integrated program of therapies, activities, and experiences designed to meet these objectives.

4. result from the collaborative recommendation of the patient's interdisciplinary treatment team.

5. be maintained and updated with progress notes, and be kept in the patient's medical record on a form developed by the facility and approved by the Department.

B. When conditions prevent the full cooperation, understanding and consent of the person in treatment, the treatment plan shall state when and by whom the person in treatment was advised of the steps of the plan.

C. Full consideration shall be given to alternative less restrictive forms of treatment. The treatment plan shall indicate what less restrictive alternatives were considered and why they were not utilized.

D. Individualized treatment plans shall be written in terms easily understood by the person in treatment, and a copy of the current treatment plan shall be available for review by the person in treatment.

E. When the most appropriate form of treatment for the individual is not available or is too expensive to be feasible, that fact shall be noted on the treatment plan form.

§ 7100.1.6.3. Review and Periodic Reexamination.

A. Every person who is in treatment shall be examined by his or her treatment team and a review made of his or her treatment plan not less than once every 30 days.

B. On the basis of reexamination and review, the treatment team may either authorize continuation of the existing treatment plan, if appropriate, formulate a new individualized treatment plan, or recommend to the director the discharge of the person.

C. A person shall not remain in treatment or under any particular mode of treatment for longer than such treatment is necessary and appropriate to his or her needs.

D. The treatment team responsible for the treatment plan shall maintain a record of each reexamination and review for each person in treatment which shall include:

1. A report of the reexamination, including a diagnosis and prognosis; and

2. A brief description of the treatment provided to the person during the period preceding the reexamination and the results of that treatment; and

3. A statement of the reason for discharge or for continued treatment; and

4. An individualized treatment plan for the next period, if any; and

5. A statement of the reasons that such treatment plan imposes the least restrictive alternative consistent with adequate treatment of his condition; and

6. A certification that the adequate treatment recommended is available and will be afforded in the treatment program.

§ 7100.1.6.4. Appeal.

A. All facilities shall have a clearly defined appeal system whereby any patient who wishes to voice objections concerning the treatment modalities offered shall be heard, and shall have his or her treatment plan reviewed by a mental health professional independent of the treatment team who shall make a report of his or her review to the director of the facility.

B. All patients shall be advised in writing of such system and encouraged to use it when they believe their treatment plan is not necessary and appropriate to their needs.

§ 7100.1.7. Confidentiality.

§ 7100.1.7.1. Consent.

A. Except as otherwise provided, all records concerning persons in treatment shall be kept confidential and shall only be released or their contents disclosed, with the prior written informed consent of the person treated or being treated.

B. A person treated or being treated may request access to records concerning his or her treatment, and shall be denied access only if:

1. upon substantial documentation by the treatment team, it is determined that disclosure of the documents concerning treatment will constitute a substantial and detriment to the treatment of the person.

2. disclosure of the documents will reveal the identity of informants who have provided information on an agreement to remain anonymous. Such an agreement may be granted only upon a determination that the identity of the informant would pose a serious risk to the safety of the informant.

C. The Director of the facility may require that a mental health professional who is a member of the treatment team, who has reviewed the record in advance, be present when the patient examines the record to aid in the interpretation of documents in the record.

If a person is denied access to all or part of his or her record, such fact and the grounds for such denial shall be noted in the persons's record.

§ 7100.1.7.2. Without Consent.

A. Relevant documents relating to a person treated or being treated may be released without the consent of the person, only to:

1. those actively engaged in providing treatment for the person, including prison physicians and psychiatrists in cases where the person has been placed in a county or state correctional facility upon discharge from the mental health facility, or

2. third party payors operated and financed, in whole or part, by any governmental agency who require information to verify that services were or were not provided; or

3. the Administrator pursuant to Section 7100.1.9.3. of these regulations; or

4. a court or mental health review officer in the course of legal proceedings authorized by the Act and these regulations; or

§ 7100.1.7.3. Privileged Communications.

Notwithstanding any other provisions of the Act or these regulations, privileged communications, whether written or oral, shall not be disclosed to anyone without the prior written informed consent of the person who made the confidential communication.

§ 7100.1.7.4. Data Collection.

A. Collection and analysis of clinical or statistical data by the Department, the Administrator, or the facility, may be undertaken as long as the use or dissemination of such data does not identify individual patients.

B. Surveys conducted for certification purposes pursuant to Titles XVIII and XIX of the Social Security Act, for accreditation purposes, or for any other purpose related to the operation of the facility, may collect and analyze data so long as the data does not identify individual patients.

§ 7100.1.7.5. Drug and Alcohol Abuse Control Acts.

The disclosure of information concerning persons in treatment funded in whole or in part by the Governor's Council on Drug and Alcohol Abuse shall be governed by regulations of the Governor's Council pursuant to Section 8 of the Pennsylvania Drug and Alcohol Abuse Control Act even though the person is mentally ill or receiving treatment at a facility as defined by these regulations.

§ 7100.1.8. Mental Health Review Officer and Proceedings.

§ 7100.1.8.1. Proceedings.

Legal proceedings concerning extended involuntary emergency treatment, court-ordered involuntary emergency treatment, or a hearing held under Section 7100.2.3.2. may be conducted by a judge of the Court of Common Pleas or by a Mental Health Review Officer authorized by the court to conduct the proceedings.

§ 7100.1.8.2. Consultation and Education.

The Administrator may, in discharging his or her duties under the Mental Health and Mental Retardation Act of 1966, provide the court or Mental Health Review Officer with:

1. education and training regarding principles and practices of mental health services;

2. administrative consultation regarding the nature and availability of approved and designated mental health facilities and services; and

3. case consultation if so ordered by the court or Mental Health Review Officer.

§ 7100.1.9. Written Applications, Petitions, Statements and Certifications.

A. Written application, petitions, statements and certifications required under these regulations shall be made upon forms issued or approved by the Department.

B. The forms listed in paragraph 7100.1.9.1. of this Section and set forth in Appendix A of these regulations have been issued by the Department, and their use is mandated. No substitution for such forms shall be permitted without prior written authorization of the Deputy Secretary for Mental Health, or his or her designee.

C. Other forms required under these regulations may be developed by the Administrator or the facility but are subject to the approval of the Department.

§ 7100.1.9.1. Forms Issued by the Department:

A. Reference

All references to Article or Section numbers in the title of the Forms issued by the Department refer to Article or Section numbers of the Act.

B. Forms

MH 781 Consent for Voluntary Inpatient Treatment (Article II)
MH 781-A Initial Evaluation
MH 781-B Explanation of Voluntary Admission Rights (Adult)
MH 781-C Explanation of Voluntary Admission Rights (Minor between 14 and 18 years of age)
MH 781-D Explanation of Voluntary Admission Rights (Minor under 14 years of age)
MH 781-E Notification of Admission of Child (For parents or guardian of minor 14-18 years old)
MH 781-F Request to Withdraw from Treatment
MH 782 Patients' Bill of Rights
MH 783 Application for Involuntary Emergency Examination and Treatment (Section 302)
MH 783-A Explanation of Rights under Emergency Involuntary Treatment
MH 783-B Explanation of Warrant (Section 302 a. 1.)
MH 784 Application for Extended Involuntary Treatment (Section 303)
MH 784-A Notice of Intent to File or Petition for Extended Involuntary Treatment and Explanation of Rights (Section 303)
MH 785 Petition for Involuntary Treatment (Sections 304 or 305)
MH 785-A Notice of Intent to File a Petition for Extended Involuntary Treatment and Explanation of Rights (304 or 305)
MH 785-B Notice of a Hearing on Petition for Involuntary Treatment and Explanation of Rights (304 c)
MH 786 Petition for Involuntary Treatment — Through the Criminal Justice System (Sections 304 or 305 via Sections 403, 404, or 405)
MH 786-A Notice of Intent to File a Petition for (Extended) Involuntary Treatment at a Mental Health Facility and Explanation of Rights (304 or 305 and 403, 404 or 405)
MH 787 Petition for Commitment for Involuntary Treatment After Finding of Incompetence to Stand Trial Where Severe Mental Disability Is Not Present (Section 402 B)
MH/MR 50 Patient Consent to Transfer

§ 7100.1.9.2. Unsworn Falsification.

A. All written statements made pursuant to Section 7100.3.3. of these regulations and all applications, petitions and certifications required under these regulations and set forth in Section

7100.1.9. shall be made subject to the penalties provided under 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and shall contain the following notice:

"ANY PERSON WHO PROVIDES ANY FALSE INFORMATION ON PURPOSE WHEN HE COMPLETES THIS FORM MAY BE SUBJECT TO CRIMINAL PROSECUTION AND MAY FACE CRIMINAL PENALTIES INCLUDING CONVICTION OF A MISDEMEANOR."

B. Documents which shall contain a notice relating to unsworn falsification: MH 781, 783, 784, 785, 786, 787.

§ 7100.1.9.3. Filing.

A. All applications, petitions, statements and certifications required under these regulations, and set forth in paragraph C of this Section shall be filed with the Administrator in the county where the person was made subject to examination and treatment and such other county in the Commonwealth, if any, in which the person usually resides.

B. The Administrator shall review all such applications, petitions, statements and certifications to determine whether the services needed are available and to assure a continuity of care.

C. Documents which shall be filed with the Administrator: MH 781, 783, 784, 785, 786, 787.

§ 7100.1.10. Rights and Remedies of Persons in Treatment.

§ 7100.1.10.1. Preservation of Rights.

A. Every person who is in treatment shall be entitled to all other rights now or hereafter provided under the laws of this Commonwealth, in addition to any rights provided for in the Act or these regulations.

B. Persons subject to treatment in accordance with these regulations shall retain all civil rights that have not been specifically curtailed by a separate judicial or administrative determination by the appropriate legal authority.

§ 7100.1.10.2. Statement of Principle.

Upon voluntary or involuntary admission to a facility, each patient, his or her family, guardian, attorney and other interested parties, shall be given a written statement of the Patient Bill of Rights to which shall be appended names, addresses, and telephone numbers of legal and other available advocacy services. Assistance in contacting a legal or other advocate shall be provided by the facility to each patient upon request. When the patient is unable to read, the Bill of Rights shall be read and explained to the patient. The Patient Bill of Rights shall, in addition, be prominently posted by the facility in each patient's living unit and treatment area.

The Patient Bill of Rights shall be provided also to each person presently in treatment. When the patient is unable to read, the Bill of Rights shall be read and explained to the patient. Upon request, a complete copy of the Bill of Rights shall be made available to the family, guardian, attorney and other interested parties at places indicated.

A signed receipt of the Bill of Rights shall be obtained from the patient by the facility, when possible. If it is impossible to obtain a receipt, such shall be documented in the records.

BILL OF RIGHTS

§ 7100.1.10.3.

YOU HAVE A RIGHT TO BE TREATED WITH DIGNITY AND RESPECT

YOU SHALL RETAIN ALL CIVIL RIGHTS THAT HAVE NOT BEEN SPECIFICALLY CURTAILED BY ORDER OF COURT

1. You have the right to unrestricted and private communication inside and outside this facility including the following rights:

a. To peaceful assembly and to join with other patients. To participate in or organize a body of patient government when patient government has been determined to be feasible by the facility.

b. To be assisted by any advocate of your choice in the assertion of your rights and to see a lawyer in private at any time.

c. To make complaints and to have your complaints heard and decided promptly.

d. To receive visitors of your own choice at reasonable hours unless your treatment team has determined in advance that a visitor or visitors would seriously interfere with your or others treatment or welfare.

e. To receive and send unopened letters and to have outgoing letters stamped and mailed. Incoming mail may be examined for good reason in your presence for contraband. Contraband means specific property which entails a threat to your health and welfare or to the hospital community.

f. To have access to telephones designated for patient use.

2. You have the right to practice the religion of your choice or to abstain from religious practices.

3. You have the right to keep and to use personal possessions, unless it has been determined that specific personal property is contraband. The reasons for imposing any limitation and its scope must be clearly defined, recorded and explained to you. You have the right to sell any personal article you make and keep the proceeds from its sale.

4. You have the right to handle your personal affairs including making contracts, holding a driver's license or professional license, marrying or obtaining a divorce and writing a will.

5. You have the right to participate in the development and review of your treatment plan.

6. You have the right to receive treatment in the least restrictive setting within the facility necessary to accomplish the treatment goals.

7. You have the right to be discharged from the facility as soon as you no longer need care and treatment.

8. You have the right not to be subjected to any harsh or unusual treatment.

9. If you have been involuntarily committed in accordance with civil court proceedings, and you are not receiving treatment, and you are not dangerous to yourself or others, and you can survive safely in the community, you have the right to be discharged from the facility.

10. You have a right to be paid for any work you do which benefits the operation and maintenance of the facility in accordance with existing Federal Wage and Hour Regulations.

§ 7100.1.10.4. Notification of Rights.

Upon receipt of a person for treatment the facility shall advise the individual of his rights, and obtain a written acknowledgement by the person that he has received and understood his rights as it affects his treatment. In the event that conditions prevent such acknowledgement and/or understanding, the process of notification shall be recorded by the person so designated and confirmed by the person so witnessing.

§ 7100.1.10.5. Existing Regulations.

A. Existing regulations regarding treatment facilities and procedures continue in force to guide facilities and providers in protecting the rights of persons in treatment.

B. It shall be the responsibility of the Administrator in designating, and the Department in approving, facilities that the procedures, for affecting and protecting the rights of persons in treatment are developed and followed.

§ 7100.1.11. Immunity from Civil and Criminal Liability.

§ 7100.1.11.1. County Administrator, Directors, Physician, or Any Other Authorized Persons.

In the absence of willful misconduct or gross negligence, an Administrator, a Director of a facility, a physician or any other authorized person who participates in a decision that a person be examined or treated under these regulations and the Act, or placed under hospitalization, out-patient care or leave of absence, or that the restraints upon such person be otherwise reduced, or an Administrator or other authorized person who denies an application for involuntary emergency

examination and treatment, shall not be civilly or criminally liable for such decision or for any of its consequences.

§ 7100.1.11.2. Judges or Mental Health Review Officers.

A Judge or mental health review officer shall not be civilly or criminally liable for any actions or decisions made by him pursuant to the authority conferred by the Act or these regulations.

§ 7100.1.12. Venue and Location of Legal Proceedings.

§ 7100.1.12.1. A. Proceedings Relating to Treatment.

1. The jurisdiction of the Courts of Common Pleas and Juvenile Courts conferred by the Act shall be exercised initially by the Court for the county in which the person subject to the proceedings is/or where he or she resides.

2. Whenever involuntary treatment is ordered, jurisdiction over any subsequent proceedings shall be retained by the Court in which the initial proceeding took place. Upon application of the person subject to the proceedings, or his or her lawyer, the Court may, for good cause shown, transfer jurisdiction to the Court in the county of the person's usual residence.

c. In all cases, a Judge of the Court of Common Pleas or a mental health review officer of the county of venue may conduct legal proceedings at a facility where the person is in treatment whether or not its location is within that county.

§ 7100.1.13. Agencies of the United States.

A. Approval.

Facilities operated under the direct control of an Agency of the United States shall not be subject to approval by the Department.

B. Confidentiality.

Where treatment is or has been provided in a facility operated by an Agency of the United States, all records concerning persons in treatment shall be kept confidential and shall only be released or their contents disclosed, with the written consent of the person treated or being treated, unless disclosed pursuant to Federal rules, statutes and resolutions governing disclosure of patient information.

C. Treatment.

1. Any person who desires voluntary treatment may apply directly to a facility operated by an agency of the United States.

2. Treatment may be ordered under Section 7100.3. et seq. of these regulations at a facility operated by an agency of the United States when such facility is able and willing to provide adequate treatment.

3. No person subject to examination and treatment under Section 7100.4. *et seq.* of these regulations shall be admitted or transferred to a facility operated by an agency of the United States if the admission or commitment requires the facility to:

a. Prepare competency reports; or

b. enforce conditions of security or maintain custody and control over such person; or

c. return the person to an authority entitled to have the person in custody.

§ 7100.2. Voluntary Examination and Treatment.

§ 7100.2.1. Application for Voluntary Examination and Treatment.

§ 7100.2.1.1. Persons Who May Authorize Voluntary Treatment.

A. Any person 14 years of age or over who believes that he or she is in need of treatment and substantially understands the nature of voluntary admission may submit himself or herself to treatment, provided that the decision to do so is made voluntarily.

B. A parent, guardian, or person standing in loco parentis to a person less than 14 years of age who believes that such child is in need of treatment, and who substantially understands the nature of voluntary admission may submit such child to examination and treatment, provided that the person making the application does so voluntarily. In making such application, the applicant shall be deemed to be acting for the child.

C. Except as otherwise authorized in these regulations, all of the provisions of these regulations governing examination and treatment shall apply.

§ 7100.2.1.2. To Whom Application Shall Be Made.

A. Except as provided in paragraph B of this Section, written application may be made to an approved facility, or to the County Administrator, upon Form MH-781, issued by the Department annexed hereto.

B. A State-operated facility shall not accept an application for voluntary treatment unless:

1. There is a pre-existing agreement of waiver approved by the Regional Deputy Secretary of Public Welfare, or his or her designee, between the State facility and the Administrator which designates that facility as the only provider of inpatient services of the County Program; or,

2. There is a pre-existing letter of agreement between the State facility and the Administrator which designates the State facility as a back-up, alternative provider of inpatient services when an emergency need arises and there are no other appropriate approved facilities available.

C. When application is made to an approved facility, the Director of the f ity shall:

1. Immediately notify the Admi trator.

2. Be responsible for having c ducted a preliminary evaluation of applicant in order to establish the ne sity and appropriateness of inpat hospitalization or outpatient or pa hospitalization service for the indivi applicant. The preliminary evalua shall be done in the least restrictive ting possible. The results of the pre nary evaluation shall be set forth Form MH-781-A issued by the Dep ment and annexed hereto.

D. When application is made to Administrator, he or she shall design an approved facility for conducting a liminary evaluation of the applican order to establish the necessity and propriateness of inpatient hospital tion or outpatient or partial hospital tion service for the individual applic The designated facility shall, mediately upon its completion of preliminary evaluation, notify the ministrator of its findings and rec mendations. Upon receipt of the rep the Administrator shall review the re and if necessary, designated an proved facility for the treatment of individual applicant.

§ 7100.2.2. Explanation and Consent Treatment.

§ 7100.2.2.1. Explanation.

A. Before a person is accepted for untary treatment an explanation shall made to him or her of the findings of preliminary evaluation and the prope treatment including the type of diagn tic and therapeutic procedures in wh he or she may be involved and the straints, restrictions, and medications which he or she may be subject.

B. Before a person is accepted for untary treatment an explanation shall made to him or her of the rights and sponsibilities of persons in volunt treatment. Such person shall also provided with a copy of the Patient's of Rights, Form MH-782 issued by Department and annexed hereto.

§ 7100.2.2.2. Consent to Treatment.

A. Before a person is accepted for untary treatment, his or her inform consent to treatment shall be obtained writing upon Form MH-781 B, C or issued by the Department and annex hereto.

B. Informed consent shall include t following elements:

1. An understanding that the tre ment proposed will involve outpatie partial hospitalization, or inpatie status;

2. A willingness to be admitted to designated facility for the purpose

examination and treatment as described;

3. That such consent is given to the proposed treatment voluntarily without coercion or duress;

4. That he or she has been provided with a full explanation of the proposed treatment and the rights and responsibilities of persons in voluntary treatment.

C. If the proposed treatment includes inpatient status, informed consent may include the applicant's voluntary agreement to remain in treatment for a specified period not to exceed 72 hours after having given written notice of intent to withdraw from voluntary treatment.

D. Written consent to voluntary treatment shall be made part of the patient's record.

E. In the event that the informed consent of the applicant cannot be obtained in writing, an affidavit, on a form approved by the Department, documenting that the applicant acknowledged the explanation given and behaviorally indicated his or her consent shall be signed by the person presenting the information and at least one witness. Such affidavit shall be made part of the patient's record.

§ 7100.2.3. Voluntary Inpatient Treatment of Minors.

§ 7100.2.3.1. Notice to Parents.

A. Upon the acceptance of an application for examination and treatment of a minor 14 years or older, but less than 18 years of age, the Director of the facility shall promptly give notice of such fact to the minor's parents, guardian, or person standing in loco parentis, by telephone if possible and by delivery of Form MH-781 E, issued by the Department and annexed hereto. Such notice shall be documented in writing and shall include an explanation of the proposed treatment and the right to be heard upon the filing of an objection.

B. Whenever the Director of the facility is unable to determine the whereabouts of the parents, guardian, or person standing in loco parentis, either by reason of the inadequacy of information provided by the minor, or for other reasons, he or she shall inform the Administrator of such fact. The Administrator shall take such action as he or she deems appropriate, including notification to appropriate agencies.

§ 7100.2.3.2. Hearing Upon Objection.

A. In the event that a parent, guardian, or a person standing in loco parentis, objects to the voluntary examination and treatment, he or she may file an objection in writing with the Director of the facility, the Administrator, or a Judge or mental health review officer.

B. Whenever such objection is filed, a hearing shall be held within 72 hours by a Judge or mental health review officer, who shall determine whether or not the voluntary treatment is in the best interest of the minor.

§ 7100.2.4. Physical Examination and Formulation of Individualized Treatment Plan.

§ 7100.2.4.1. Physical Examination.

Upon completion of the preliminary evaluation and acceptance of a person for voluntary inpatient examination or treatment, the facility shall provide or arrange for a physical examination immediately.

§ 7100.2.4.2. Individualized Treatment Plan.

Within 72 hours after acceptance of a person for voluntary examination and treatment, an initial individualized treatment plan shall be formulated for the individual by a treatment team. The formulation of such treatment plan and notice to the individual as to its content shall be in accordance with Section 7100.1.6. of these regulations.

§ 7100.2.5. Transfer of Persons In Voluntary Treatment.

§ 7100.2.5.1. Consent to Transfer.

A. No person who is in voluntary treatment may be transferred from one facility to another without his or her prior written informed consent. If the transfer is to a more restrictive setting or shall place greater restrictions upon the person, the person must be so informed prior to obtaining consent.

B. If the person being transferred is a minor under 14 years of age, the consent of his or her parent, guardian, or person standing in loco parentis shall be obtained.

C. In the event that the person being transferred is a minor 14 years of age or older, but less than 18 years of age, the parents, guardian or person standing in loco parentis shall receive notice of such transfer and shall have the right to be heard upon the filing of an objection in accordance with the procedures set forth in Section 7100.2.3 of these regulations.

§ 7100.2.6. Withdrawal from Voluntary Treatment.

§ 7100.2.6.1. Notice of Withdrawal.

A. Except as provided in paragraph C of this Section, a person 14 years of age or older may withdraw from voluntary treatment at any time by giving written notice to the treating facility. Upon request to any clinical employe of the treating facility, a person seeking release from voluntary treatment shall be immediately provided with a Form MH-781F issued by the Department, and annexed hereto, which shall be signed by the individual and be returned to the facility. An adequate supply of these forms shall be available in all treatment and living areas of the facility.

B. Except as provided in paragraph C of this Section, a parent, guardian, or person standing in loco parentis may withdraw a person under 14 years of age from voluntary treatment at any time by giving written notice to the treating facility in accordance with the procedures set forth in paragraph A of this Section.

C. The person receiving Form MH-781F from the patient shall immediately examine the patient's record to determine whether the patient has previously given informed consent to remaining in treatment for a specified period not to exceed 72 hours after having given written notice of intent to withdraw from voluntary treatment. If no such consent has been given, the patient may immediately withdraw from treatment.

D. If consent to remain in treatment was given, the person examining the record shall notify the patient and a member of the treatment team of their designee, who shall be available at all times. The treating facility may delay release of such person for a period, not exceeding that specified, if the treatment team or its designee has reason to believe that:

1. The individual is severely mentally disabled as defined in Section 7100.3 of these regulations, a petition for involuntary treatment is to be filed under Section 7100.3.3 of these regulations.

2. Immediate release would be medically dangerous to the health of the individual.

E. When release of an individual from voluntary treatment is delayed in accordance with paragraph C of this Section, such individual shall be informed of the circumstances justifying the delay for the specified period of time. Such circumstances shall also be set forth in writing and made part of the patient's record.

§ 7100.2.6.2. Release of Minors Under 14 Years of Age

A. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the Court of Common Pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment.

B. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The Administrator shall provide assistance to the attorney for such minor upon request.

C. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the

attorney for such minor. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

§ 7100.2.6.3. Notice to Administrator.

The Director of the facility shall immediately notify the Administrator of the withdrawal of any person from voluntary treatment.

§ 7100.2.7. Discharge from Voluntary Inpatient Treatment.

§ 7100.2.7.1. Medical Necessity.

A. In the event that the treatment team determines that continued voluntary inpatient treatment is not medically indicated, the treatment team shall recommend discharge of the patient to the Director of the facility. The Director of the facility shall review the recommendation of the treatment team and shall determine whether discharge is appropriate.

B. When the Director of the facility determines either on the basis of recommendation of the treatment team, or upon independent review, that continued voluntary inpatient treatment is not medically indicated, and that discharge is appropriate, he or she shall advise the patient and the Administrator of this determination.

§ 7100.2.7.2. Non-acceptance of Treatment Plan.

A. In the event that any patient in voluntary inpatient treatment is unwilling to accept or cooperate with his or her individualized treatment plan, the treatment team shall advise the Director of the facility of such fact. The Director of the facility or designee shall review the circumstances including the availabilities of reasonable alternative treatment plans, and determine whether discharge is appropriate.

B. When the Director of the facility determines that the unwillingness of the patient to accept or cooperate with the individualized treatment plan, or reasonable alternative treatment plans, makes continued voluntary inpatient treatment inappropriate, he or she shall advise the patient of the voluntary nature of the treatment and the patient's right to withdraw.

C. In the event that the patient continues to fail to accept or cooperate with the individualized treatment plan, or reasonable alternative treatment plans, and fails to withdraw from voluntary inpatient treatment, the Director of the facility shall advise the patient and the Administrator of his or her determination that discharge is appropriate.

§ 7100.3. Involuntary Examination and Treatment.

§ 7100.3.1. Persons Subject to Involuntary Examination and Treatment.

A. A person who is severely mentally disabled and in need of treatment, may be made subject to involuntary examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his or her capacity to exercise self-control, judgment and discretion in the conduct of his or her affairs and social relations or to care for his or her own personal needs is so lessened that he or she poses a clear and present danger of harm to others or to himself or herself.

B. A determination of clear and present danger shall be shown by establishing that *within the past 30 days:*

1. The person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated; or

2. The person has been found incompetent to be tried or has been acquitted by reason of lack of criminal responsibility on charges arising from conduct involving infliction of or attempt to inflict substantial bodily harm on another, and that the conduct charged in the criminal proceeding did occur, and that there is reasonable probability that such conduct will be repeated; or

3. The person has acted in such manner as to evidence that he or she would be unable, without care, supervision and the continued assistance of others, to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded; or

4. The person has attempted suicide and that there is a reasonable probability of suicide unless adequate treatment is afforded; or

5. The person has severely mutilated himself or herself or attempted to mutilate himself or herself severely and that there is the reasonable probability of mutilation unless adequate treatment is afforded.

C. A person who is severely mentally disabled as defined herein, and *in need of immediate treatment*, may be subject to emergency examination and treatment in accordance with the provisions of Section 7100.3.3. of these regulations.

§ 7100.3.2. Persons Under 18 Years of Age.

Persons under 18 years of age may be subject to involuntary examination and treatment or involuntary emergency examination and treatment only in a mental health facility designated appropriate for the treatment of children or adolescents by the Administrator in the county of residence. Should no such facility exist within the county of residence, the nearest appropriate facility shall be selected by the Administrator of the county of residence in cooperation with the Administrator of the county where the facility is located, and shall be reviewed by the Regional Commissioner of Mental Health or his or her designee.

§ 7100.3.3. Involuntary Emergency Examination and Treatment.

§ 7100.3.3.1. Persons Subject to Involuntary Emergency Examination and Treatment.

In accordance with the procedures set forth in Section 7100.3, a person may be subject to emergency examination and treatment for a period not to exceed 72 hours, at a designated and approved facility, if there are reasonable grounds to believe that such person is severely mentally disabled as defined in Section 7100.3.1.A of these regulations, and in need of immediate treatment.

§ 7100.3.3.2. Designated Facilities to Provide Involuntary Emergency Examination and Treatment Authorization.

A. Except as provided in paragraph B of this Section, written application may be made to an approved and designated involuntary emergency examination and treatment facility, or to the Administrator, upon Form MH-783, issued by the Department annexed hereto.

B. A State-operated facility shall not accept an application for involuntary examination and treatment unless:

1. There is a pre-existing agreement of waiver approved by the Regional Deputy Secretary of Public Welfare, or his or her designee, between the State facility and the Administrator which designates that facility as the only provider of inpatient services of the County Program; or

2. There is a pre-existing letter of agreement between the State facility and the Administrator which designates the State facility as a back-up alternative provider of inpatient services when an emergency need arises and there are no other appropriate approved facilities available.

C. The Administrator shall make known to the public the facilities designated to provide involuntary emergency examination and treatment and their service capability, availability, the procedures required under these regulations.

D. Prior to the designation of any facility in Section A, above, the Administrator shall establish in writing the responsibilities and procedures of such facility pursuant to Sections 7100.3.3.4 C and D of these regulations. Such written statement shall be acknowledged and agreed to by the facility prior to the designation.

§ 7100.3.3.3. Initiation of Involuntary Emergency Examination and Treatment.

A. Upon written application by a physician or other responsible party set-

ting forth facts constituting reasonable grounds to believe that a person is severely mentally disabled and in need of immediate treatment, the Administrator may issue a warrant requiring a person authorized by him or her, or any peace officer to take such person to a facility specified in the warrant. The warrant shall be upon Form MH-783 issued by the Department annexed hereto, and shall be signed by the Administrator or his or her designee.

B. Upon personal observation of conduct constituting reasonable grounds to believe that the person engaging in the conduct is severely mentally disabled and in need of immediate treatment, a physician or peace officer or designee of the Administrator, may take such person to a facility designated by the Administrator as an emergency treatment facility. Upon arrival, the physician, peace officer, or designee of the Administrator, shall make a written statement upon Form MH-783 issued by the Department, annexed hereto, by setting forth the personal observation of the conduct which led the individual to believe that the person is severely mentally disabled and in need of immediate treatment.

C. Notwithstanding paragraph A of this Section, any physician who has personally observed the conduct of a person constituting reasonable grounds to believe that such person is severely mentally disabled and in need of immediate treatment, and who further has reason to believe that he or she shall be the examining physician at the treatment facility, shall be required to obtain a warrant for the emergency examination from the Administrator in accordance with the procedures set forth in paragraph A of this Section.

D. Any persons authorized under this Section to take a person to a treatment facility for involuntary emergency examination and treatment shall explain to the person in need of such treatment the nature and purpose of the action to be undertaken, and shall deliver to such person Form MH-783-B, issued by the Department annexed hereto. The escorting individual shall make every effort to use the least force necessary and shall act to the extent possible in a courteous manner toward such individual giving attention to the dignity of the person.

§ 7100.3.3.4. Examination Preliminaries.

A. Upon arrival at the facility the person shall be informed of the reasons for and nature of the involuntary emergency examination and of the right to communicate immediately with others. The facility shall deliver Forms MH-782 and MH-783-A issued by the Department annexed hereto.

B. He or she shall be allowed immediate reasonable use of the telephone. Reasonable use of the telephone shall mean at least three completed phone calls. If assistance is required, the facility shall assist the individual in completing phone calls. The cost of any toll calls shall be borne by the person in need of treatment, although actual payment shall not be a pre-condituon to use of the telephone.

C. The treating facility shall immediately undertake to determine whether immediate steps must be taken to assure that the health and safety needs of any dependents of the person are safeguarded and that his or her personal property and premises are secured.

D. The Facility shall also immediately notify the Administrator of the arrival of such person and shall coordinate with the Administrator any steps which must be undertaken in accordance with paragraph C of this Section.

E. The Administrator shall specify in writing the procedures to be followed by his or her office, and those facilities designated as the provider of involuntary emergency examination and treatment in carrying out the responsibilities of paragraph C and D of this Section. These procedures must specify what types and immediate steps shall be taken, how quickly they shall be taken, and who is responsible for them. Such procedures shall be based on the availability of resources within the community.

§ 7100.3.3.5. Involuntary Emergency Examination.

A. A person taken to a facility for involuntary emergency examination shall be examined by a physician as soon as possible but in any event within two hours of arrival in order to determine if the person is severely mentally disabled as defined in Section 7100.3-1.A of these regulations and in need of immediate treatment. The physician shall record the examination findings in the patient's record.

B. If the examining physician determines that the person is not severely mentally disabled or not in need of immediate treatment, the person shall be immediately discharged and returned to such place as he or she may reasonably direct. The Administrator shall be notified of the results of the examination and shall assure that such person is provided with transportation to such appropriate location within the community as he or she may request.

C. If the examining physician determines that the person is severely mentally disabled and in need of immediate treatment, the Administrator and the Director of the facility shall be immediately so notified.

D. The Administrator and the Director of the facility shall determine if a previous application for involuntary emergency treatment was granted on the basis of the behavior supporting the determination of the physician. In no event, shall a person be accepted for involuntary emergency treatment if a previous application was granted for such treatment and the new application is not based on behavior occurring after the earlier application.

§ 7100.3.3.6. Involuntary Emergency Treatment.

A. Any person determined after examination to be severely mentally disabled as defined in Section 7100.3 *et seq.* of these regulations, in need of immediate treatment shall be so notified immediately by the examining physician. The examining physician shall deliver Form MH-783A issued by the Department, annexed hereto to such person.

B. Such individual shall be requested to furnish the names of up to three parties whom he or she may want notified and kept informed by his or her status.

C. The facility shall give notice to the parties identified of the whereabouts and the status of the person, how and when the person may be contacted and visited, and how they may obtain information concerning the individual while he or she is in inpatient treatment. The parties shall be informed of any major change in the person's status, including transfer, escape, major change in medical condition, or discharge.

D. The person shall be informed of his or her right to counsel, and be advised that if he or she cannot afford counsel, counsel can be provided.

E. The facility shall take reasonable steps with the Administrator to assure that while the person is detained the health and safety needs of any dependents are met and that his or her personal property and premises are secured. (Per Section 7100.3.3.3. C, D, & E).

F. The involuntary emgergency treatment of the individual, or the arrangement of such, shall be initiated immediately, but shall be limited to the purposes of responding to the emergency and to performing diagnosis and evaluation of the individual, and that necessary treatment required to provide health and safety to the individual and to others, unless the individual gives informed consent to additional treatment.

§ 7100.3.3.7. Duration of Involuntary Emergency Treatment.

A person who is in involuntary emergency treatment shall be discharged whenever it is determined that he or she is no longer in need of treatment and in any event within 72 hours after entering the facility, unless within such period:

1. He or she is admitted to voluntary treatment; or

2. A certification for extended involuntary emergency treatment is

granted by a Judge or mental health review officer after a hearing in accordance with Section 7100.3.4. of these regulations.

§ 7100.3.4. Extended Involuntary Emergency Treatment.

§ 7100.3.4.1. Persons Subject to Extended Involuntary Emergency Treatment.

In accordance with the procedures set forth in Section 7100.3.4 the person may be subject to extended involuntary emergency treatment for a period not to exceed 20 additional days if such person is receiving emergency treatment and the treating facility determines that the need for emergency treatment is likely to extend beyond 72 hours.

§ 7100.3.4.2. Initiation of Extended Involuntary Emergency Treatment.

A. Within 48 hours after initiation of emergency involuntary treatment, the treating facility shall reassess the mental condition of the individual receiving such treatment and shall determine whether the need for emergency treatment is likely to extend beyond the initial 72 hours.

B. If the facility determines that extended emergency involuntary treatment is necessary, it shall immediately deliver an application upon Form MH-784 issued by the Department, annexed hereto, to the Court of Common Pleas and shall notify the individual of such fact by delivery of Form MH-784A issued by the Department, annexed hereto. It shall also so notify the parties identified by the individual.

C. The application shall state the grounds on which the person is believed to be mentally disabled as defined in Section 7100.3.1.A of these regulations and in need of extended involuntary emergency treatment. It shall also contain the name of any examining physician and the substance of his or her opinion regarding the mental condition of the person. The application shall also be signed by the examining physician.

D. If at any time after an application for extended emergency treatment has been filed, the facility shall reverse its determination that extended emergency treatment is necessary, it shall withdraw the application and shall discharge the person.

E. The Administrator shall be notified of all actions taken by the facility under this Section.

§ 7100.3.4.3. Informal Hearing.

A. Immediately upon receiving an application for extended emergency treatment, the Court of Common Pleas shall appoint an attorney who shall represent the person unless the Court determines that private representation is available.

B. Within 24 hours after the application is received an informal hearing shall be conducted by a Judge or mental health review officer. If practical, such informal hearing shall be held at the treatment facility.

C. At the commencement of the informal hearing, the Judge or mental health review officer shall inform the person of the nature of the proceedings and of his or her rights.

D. The treatment facility shall present to the Judge or mental health review officer all information relevant to the determination as to whether the person is severely mentally disabled and in need of extended emergency treatment. Relevant information shall include:

1. Evidence of person's conduct upon which a determination of mental disability as defined in Section 7100.3 1. of these regulations may be based; and

2. The reasons why extended involuntary treatment is considered necessary; and

3. A description of the treatment to be provided; and

4. An explanation of the adequacy and appropriateness of such treatment for the individual including why such treatment poses the least restrictive alternative for the individual; and

5. Documentation that the proposed treatment is available at the facility and will be afforded to the individual in the treatment program.

E. All information regarding treatment shall be presented by a physician who has examined the person and shall be in terms understandable to a layperson.

F. The person or his or her representative shall have the right to cross-examine the physician and any other person whose evidence has been introduced into the record and may present any additional relevant information.

G. The Judge or mental health review officer shall review the information presented and shall make a finding as to whether the person is severely mentally disabled and in need of extended emergency treatment.

H. If the Judge or mental health review officer determines that the person is severely mentally disabled and in need of extended involuntary emergency treatment, he or she shall so certify in accordance with paragraph D of this Section 7100.3.4.4.

I. If the Judge or mental health review officer determines that the person is not severely mentally disabled or not in need of extended emergency treatment, he or she shall direct that the Director of the facility or his or her designee discharge the person.

J. A stenographic or other sufficient record of the proceedings shall be made of the hearing. Such record shall be kept by the Court or mental health review officer for at least one year.

§ 7100.3.4.4. Certification for Extended Involuntary Emergency Treatment.

A. A certification for extended involuntary treatment shall be made by the Judge or mental health review officer in writing upon Form MH-7[illegible] issued by the Department, annexed hereto.

B. The certification shall include the following:

1. Findings by the Judge or mental health review officer supporting the reasons why the individual is mentally disabled and extended involuntary emergency treatment is necessary.

2. A description of the treatment provided and an explanation of the adequacy and appropriateness of such treatment and the availability of such treatment at the treatment facility. The description shall be based upon information received at the informal hearing.

3. All documents and forms required under Section 7100.3.3 of these regulations to provide emergency examination and treatment;

4. The application filed by the facility for extended involuntary emergency treatment;

5. A statement that the person was represented by counsel at the informal hearing and the name and address of such counsel;

6. An explanation of the effect of the certification, the person's right to petition the Court for review of the certification if heard by a mental health review officer, and the person's continuing right to be represented by counsel.

C. Certification shall be filed immediately with the Director of the facility and a copy served on the person and such other parties as the person requested to be notified in Section 7100.3.3.5(B). of these regulations on counsel.

§ 7100.3.4.5. Effect of Certification.

A. Upon the filing and service of a certification for extended involuntary emergency treatment, the person may be given treatment in the facility for a period not to exceed 20 additional days.

B. A certification filed and served shall remain in effect notwithstanding a petition for review of the certification unless a ruling to the contrary is issued by the Court.

§ 7100.3.4.6. Review of Certification.

A. In all cases in which the informal hearing was conducted by a mental health review officer, a person determined to be mentally disabled and in need of extended emergency treatment shall have the right to petition the Court of Common Pleas for a review of the certification.

B. A hearing shall be held by the Court within 72 hours after the pe[illegible]

is filed unless a continuance is requested by the person's counsel.

C. The hearing shall include a review of the certification and such evidence as the Court may receive or require.

D. If the Court determines that the person is mentally disabled and in need of extended emergency treatment and that the procedures prescribed by these regulations and under law have been followed, the petition shall be denied. If the Court does not so determine, the facility shall discharge the person.

§ 7100.3.4.7. Duration of Extended Emergeney Treatment.

A person who is in extended emergency treatment shall be discharged whenever it is determined that he or she is no longer severely mentally disabled or is no longer in need of immediate treatment and in any event within 20 days, after the filing of the certification unless within such period:

1. He or she is admitted to voluntary treatment;

2. The Court orders involuntary treatment not to exceed 90 days.

§ 7100.3.5. Court Ordered Involuntary Treatment Not to Exceed Ninety Days.

§ 7100.3.5.1. Persons Subjected to Court Ordered Involuntary Treatment Not to Exceed Ninety Days.

Any person who is severely mentally disabled as defined in Section 7100.3.1.A. of these regulations and in need of treatment may be made subject to court ordered involuntary treatment upon a court determination of clear and present danger to himself or herself or to others.

§ 7100.3.5.2. Initiation of Court Ordered Involuntary Treatment for Persons Already Subject to Involuntary Treatment.

A. A petition for court ordered involuntary treatment for persons already subject to involuntary treatment under Sections 7100.3.4. and 7100.3.5. and 7100.3.6. of these regulations may be made by the Administrator upon a determination that a person is severely mentally disabled and in need of continued treatment.

B. If the Director of the treating facility determines that continued involuntary treatment of a person already subject to involuntary treatment is necessary, he or she shall notify the Administrator of such fact.

C. In the event that the Administrator disagrees with the determination of the Director of the facility he or she shall immediately bring such disagreement to the attention of the Regional Commissioner of Mental Health, and shall so notify the Director of the facility. Any dispute as to the appropriateness of the proposed continuation of involuntary treatment shall be decided within 24 hours by the Regional Commissioner or his or her designee.

D. When it is determined on the basis of the recommendation of the Director of the facility or upon an independent review by the Administrator or upon determination by the Regional Commissioner of Mental Health or his or her designee that continued involuntary treatment is necessary, the Administrator shall file a petition for court ordered involuntary treatment with the Court of Common Pleas, and shall so notify the Director of the facility. The petition shall be filed not less than five days prior to the expiration of involuntary treatment under Sections 7100.3.4., 7100.3.5. or 7100.3.6. of these regulations.

E. The Director of the facility shall immediately notify the person of the intent to file a petition for court ordered involuntary treatment with the Court of Common Pleas by delivering to such person Form MH 785A issued by the Department, annexed hereto.

F. The petition shall be upon Form MH 785 issued by the Department, annexed hereto and shall include a statement of the facts constituting reasonable grounds to believe that the person is severely mentally disabled and in need of treatment.

G. The petition shall be sufficient if it represents that the conduct originally established to subject the person to involuntary treatment did in fact occur and that the person's condition continues to evidence a clear and present danger to himself or herself or others. It shall not be necessary to show the recurrence of the dangerous conduct, either harmful or debilitating, within the past 30 days.

H. The petition shall state the name of any examining physician and the substance of his or her opinion regarding the mental condition of the person. The petition shall be signed by the examining physician.

I. The petition shall state that the person has been provided with a copy of the petition, an explanation of the nature of the proceedings, and an explanation and notice of the person's right to counsel and the services of an expert in the field of mental health.

J. The petition shall include copies of all applicable documents relating to examination and treatment of the person which are required under these regulations. Such documents shall include Forms MH 783, and 784.

K. Upon the filing of the petition the Administrator shall serve a copy of the petition on the person, his or her counsel, and those designated to be kept informed by the person. The copy shall include an explanation of the nature of the proceedings and the person's right to counsel, and the right to the services of an expert in mental health.

L. A hearing on the petition shall be held in all cases not more than five days after the filing of the petition.

M. Involuntary treatment of the person may be continued pending the determination of the petition subject to any other limitation on the period of involuntary treatment.

§ 7100.3.5.3. Initiation of Court Ordered Involuntary Treatment for Persons Not Presently Subject to Involuntary Treatment.

A. A petition for court ordered involuntary treatment for persons not in involuntary treatment may be made by any responsible party who believes upon reasonable grounds that a person is severely mentally disabled and in need of treatment.

B. If a decision to file such petition is made by the Director of a facility treating a person already in voluntary treatment, he or she shall immediately notify the Administrator. If the decision to file is made by the Administrator for a person in voluntary treatment, he or she shall immediately notify the Director of the facility.

In either case, the Director shall notify the person in voluntary treatment of the decision to file the petition by delivering to such person a copy of Form MH 785A, issued by the Department and annexed hereto.

C. The petition shall be in writing upon Form MH 785, issued by the Department and annexed hereto. It shall include a statement of such supporting facts constituting reasonable grounds to believe that the person is mentally disabled and in need of treatment. If the petition is filed by the Director of a facility or the Administrator for a person already in voluntary treatment, it shall state the name of an examining physician and the substance of his opinion regarding the mental condition of the person. In all other cases, the petition shall state the name of an examining physician, if any, and the substance of his opinion regarding the mental condition of the person.

D. Upon receipt of the petition the court shall review its content and determine whether the petition sets forth reasonable cause. Upon a positive determination, the court shall appoint an attorney to represent the person and set a date for a hearing on the petition.

E. The attorney appointed by the court shall represent the person unless the court determines that private representation is available.

F. The court by summons shall direct the person to appear for the scheduled hearing. The court may issue a warrant directing a peace officer or a person authorized by the Administrator to bring such person before the court at the time of the hearing if there are reasonable grounds to believe that the person will not appear voluntarily.

G. A copy of the petition shall be served on such person at least three days before the hearing. The person shall also receive notice advising him or her that an attorney has been appointed who shall represent him or her at the hearing unless private representation is available. Such notice shall also inform the person of his or her right to be assisted in the proceedings by an expert in the field of mental health and that he or she may request or may be subject to psychiatric examination upon motion of the court. Form 785B, issued by the Department and annexed hereto, may be used to notify the person of these rights.

H. Upon motion of either the petitioner or the person, or upon its own motion, the court may order the person to be examined by a psychiatrist appointed by the court. Such examination shall be conducted on an outpatient basis, and the person shall have the right to have counsel present. A report of the examination shall be provided to the court and counsel at least 48 hours prior to the hearing.

I. Involuntary treatment of the person shall not be authorized pending the determination of the petition except in accordance with the provisions of Section 7100.3.3 or 7100.3.4 of these regulations.

§ 7100.3.5.4. Hearings on Petition for Court Ordered Involuntary Treatment.

A. The person shall not be called as a witness without his or her consent.

B. The person shall have the right to confront and cross-examine all witnesses and to present evidence in his or her own behalf.

C. The hearing shall be public unless it is requested to be private by the person or his or her counsel.

D. A stenographic or other sufficient record shall be made, which shall be impounded by the court and may be obtained or examined only upon the request of the person or his or her counsel or by order of the court on good cause shown.

E. The hearing shall be conducted by a judge or by a mental health review officer and may be held at a location other than a courthouse when doing so appears to be in the best interest of the person.

F. A decision shall be rendered within 48 hours after the close of evidence.

§ 7100.3.5.5. Determination and Order.

A. Upon a finding by clear and convincing evidence that the person is severely mentally disabled and in need of treatment and is a clear and present danger to himself or herself or to others an order shall be entered directing treatment of the person in an approved facility as an inpatient or an outpatient.

B. Inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives. Investigations of treatment alternatives shall include consideration of the person's relationship to his or her community and family, his or her employment possibilities, all available community resources, and guardianship services. An order for inpatient treatment shall include findings on such investigations.

§ 7100.3.5.6. Duration of Court Ordered Involuntary Treatment.

A. The period of court ordered involuntary treatment may not exceed 90 days, except as provided in paragraph B below.

B. A person may be made subject to court ordered involuntary treatment in excess of 90 days but for a period not to exceed one year if:

1. The court findings of severe mental disability is based on conduct which has given rise to any of the following charges under the Pennsylvania Crimes Code: murder (2502); voluntary manslaughter (2503); aggravated assault (2702); kidnapping (2901); rape (3121(1) and (2)); involuntary deviate sexual intercourse (3123(1) and (2)); and

2. A finding of incompetency to be tried or a verdict of acquittal because of lack of criminal responsibility has been entered.

C. A person subject to court ordered involuntary treatment shall be discharged whenever the Director of the facility concludes that the person is no longer in need of continued treatment. In no event shall such person be detained beyond the period specified in the court order issued under paragraph 7100.3.5.4 unless within that period

(1) the person gives informed consent to continued voluntary treatment; or

(2) a court order for an additional period of court ordered involuntary treatment has been issued.

D. For any person subject to commitment under paragraph B of this section, the director of the facility shall require the treatment team to report every 90 days whether the person is or continues to be severely mentally disabled and in need of treatment. This report shall be reviewed by the director of the facility and forwarded to the committing court. If the treatment team finds that the person is no longer severely mentally disabled and in need of treatment, they shall recommend to the director of the facility that the person be discharged.

E. Any person who is subject to commitment in paragraph B of this section, may request the court or mental health review officer to review the basis of his or her involuntary commitment, and request a hearing by the court to determine the necessity for his or her continued treatment every 90 days.

§ 7100.3.6. Additional Periods of C Ordered Involuntary Treatment.

A. At the expiration of a peri court-ordered involuntary treat under Section 7100.3.5 of these re tions, the court may order treatme an additional period upon the applic filed at least five days prior to ter tion of Court order by the County ministrator or the Director of the fa in which the person is receiving ment.

B. A court order authorizing t ment for an additional period shall b tered upon a hearing and finding in cordance with the procedures set for 7100.3.5 of these regulations, and further finding of a need for contin involuntary treatment as shown by duct during the person's most re period of court-ordered treatment.

C. A person found dangerous to self or herself shall not be subject t additional period of involuntary full inpatient treatment unless he or she first been released to a less restrictiv ternative. If the Administrator or D tor of the facility has reasonable grou to believe that release to a less restric alternative would not be in the pers best interest, he or she shall include grounds for such belief in the applica filed under paragraph A.

§ 7100.3.7. Transfer of Persons In voluntary Treatment.

A. A person in involuntary treatm may be transferred to any approved f ity.

B. Whenever a transfer of a perso involuntary treatment will constitu greater restraint, it shall not take p unless, upon a hearing prior to the tr fer, a Judge or mental health revie ficer finds it to be necessary and ap priate.

C. When the treatment team an the Director of a facility determine th transfer of a person in involunt treatment is required, they shall n the County Administrator of the plan transfer, setting out the reasons ne sitating the transfer, which shall the reviewed by the County Administrat determine whether the services that required will be available.

D. Where a transfer of a person in voluntary treatment will involve a tr fer to another county, the County ministrator of the receiving County be notified, and shall review the tra as in paragraph C of this section.

§ 7100.4. Persons Charged With A Cr or Under Sentence.

§ 7100.4.1. Determinations Affect Those Charged with Crime, or U Sentence.

§ 7100.4.1.1. Persons Subject to Exam tion and Treatment.

A. A person who is charged wit

crime or who is undergoing sentence, who is or becomes severely mentally disabled, may be subject to involuntary examination and treatment under Section 7100.3 *et seq.* of these regulations:

B. A person who is subject to a petition or who has been committed under the Juvenile Act, who is or becomes severely mentally disabled, may be subject to involuntary examination and treatment under Section 7100.3 *et seq.* of these regulations.

§ 7100.4.1.2. Examination and Treatment.

A. Any persons subject to examination and treatment under paragraph A of Section 7100.4.1.1 may be subject to emergency examination and treatment extended emergency examination and treatment and court ordered involuntary treatment, in accordance with the procedures established for such in Section 7100.3 *et seq.* of these regulations in the same manner as if such person were not so charged or sentenced, or subject to petition or committed under the Juvenile Act.

B. Whenever a person, detained on criminal charges or incarcerated, is made subject to inpatient examination or treatment, he or she shall be transferred to a designated approved facility after proceedings have been completed in accordance with the appropriate section of Section 7100.3. *et seq.*

C. Any person who is subject to involuntary inpatient examination or treatment and is or remains subject to a detainer or sentence, or under the jurisdiction of the Juvenile Court, shall be returned to the authority entitled to have such person in custody upon discharge from treatment.

D. Any period of involuntary inpatient treatment shall be credited as time served on account of any sentence to be imposed on pending charges or any unexpired term of imprisonment.

E. Any person subject to inpatient examination and treatment shall be subject to any provisions of security imposed by the criminal or Juvenile Court having jurisdiction, provided that the facility to which the person is being committed is capable of providing the security. If the facility is unable to provide the ordered security, the Director of the facility shall immediately notify the court issuing the order.

§ 7100.4.2. Incompetence to Proceed on Criminal Charges and Lack of Criminal Responsibility as a Defense.

§ 7100.4.2.1. Persons Subject to Examination for Incompetency to Proceed on Criminal Charges.

A person who has been charged with a crime and is found to be substantially unable to understand the nature of the proceedings against him or her or to participate and assist in his or her defense, may be subject to an examination to determine whether he or she shall be deemed to be incompetent to be tried, convicted or sentenced.

§ 7100.4.2.2. Initiation of Incompetency Examination.

A. An application may be presented to the court for an order directing an incompetency examination by an attorney for the Commonwealth, a person charged with a crime, his or her counsel, or the warden or other officials in charge of the institution or place in which such person is detained.

B. The court shall ascertain whether the person charged with a crime is represented by counsel, and if not, counsel shall be appointed by the court.

C. The court, either on an application or on its own motion, may order an incompetency examination at any stage in the criminal proceedings without a hearing if there is no objection by the person charged with a crime or his or her counsel. If the person charged with a crime or his or her counsel objects to the examination, the court shall hold a hearing to determine whether a prima facie question of incompetency exists. The moving party shall have the burden of establishing incompetency by clear and convincing evidence.

§ 7100.4.2.3. Incompetency Examination.

A. When ordered by the court, an incompetency examination shall:

1. be an outpatient examination unless an inpatient examination is authorized in accordance with other provisions of these regulations; and

2. be conducted by at least one psychiatrist and may be related both to competency to proceed and to criminal responsibility for the crime charged depending upon the order of the Court.

B. The person charged with a crime shall be advised of the right to have counsel present and shall be advised of the right not to answer any questions or to perform any tests unless he or she has agreed to the examination or has moved for the examination. In any event, nothing said or done by such person during the examination may be used as evidence against such person in any criminal proceedings on any issue other than that of his or her mental condition.

C. The court may allow a psychiatrist retained by the defendant or the prosecution to witness and participate in the examination. Whenever a defendant who is financially unable to retain such expert has a substantial objection to the conclusions reached by the court-appointed psychiatrist, the court shall allow reasonable compensation for the employment of a psychiatrist of his or her selection, which amount shall be chargeable against the mental health and mental retardation program of the locality.

D. The Department shall reimburse the local mental health and mental retardation program for costs incurred under this section in accordance with the schedule set forth in Appendix B of these regulations.

E. Upon completion of the examination, a report shall be submitted to the court and to counsel and shall contain a description of the examination and shall include:

1. Diagnosis of the person's mental condition;

2. An opinion as to the person's capacity to understand the nature and object of the criminal proceedings and to assist in his or her defense;

3. When so requested by the Court, an opinion as to the person's mental condition in relation to the standards for criminal responsibility as then provided by law if it appears that the facts concerning his mental condition may also be relevant to the question of legal responsibility; and

4. When so requested by the Court, an opinion as to whether the person had the capacity to have a particular state of mind, where such state of mind is a required element of the criminal charge.

§ 7100.4.2.4. Determination.

A. Based upon the examination and report presented to the court, the court shall render a determination of the competency of the person who is detained under a criminal charge within 20 days after receipt of the report unless the hearing was continued at the person's request.

B. A person who is determined to be incompetent shall be re-examined not less than every 60 days by a psychiatrist appointed by the court and a report of re-examination shall be submitted to the court and to counsel by the psychiatrist.

C. A person who is determined to be incompetent shall be advised by the court of the continuing right to counsel so long as the criminal charges are pending.

§ 7100.4.2.5. Involuntary Treatment.

A. When a court determines that a person who is not severely mentally disabled, as defined in Section 7100.3.1 of these regulations, is incompetent to stand trial in accordance with the procedures governing such determinations, the court may order involuntary treatment of such person only if it is reasonably certain that the involuntary treatmen; will provide the person with the capacity to stand trial. This determination must be based upon a finding of the psychiatric examination, and supported in the report presented to the court.

B. Involuntary treatment under this section shall not exceed a specified period of no more than 30 days. The in-

voluntary treatment ordered by the court may be outpatient treatment, partial hospitalization or inpatient treatment. Such treatment shall be limited to reasonable attempts to make the person competent to stand trial unless the person gives informed consent to additional treatment.

§ 7100.4.2.6. Stay of Proceedings.

A. A determination of incompetency to proceed shall effect a stay of the prosecution for so long as such incapacity persists.

B. Any legal objections suitable for determination prior to trial and not requiring the personal participation of the person charged may be raised and decided in the interim.

C. In no instance shall the proceedings be stayed for a period in excess of the maximum sentence that may be imposed for the crime or crimes charged, or five years, whichever is less.

§ 7100.4.2.7. Effect on Criminal Detention.

A. A person who has been determined to be incompetent to proceed shall not, for that reason alone be denied pre-trial release.

B. Such person shall not be detained on the criminal charge any longer than the reasonable period of time necessary to determine whether there is a substantial probability that he or she will attain that capacity in the foreseeable future. If the court determines that there is not such probability, it shall discharge the person. Otherwise, such person may be criminally detained so long as such probability exists, but in no event longer than the maximum sentence that may be imposed for the crime or crimes charged, or five years, whichever is less.

§ 7100.4.2.8. Resumption of Proceedings or Dismissal.

A. When the court, on its own motion or upon the application of the attorney for the Commonwealth or counsel for the defendant, determines that such person has regained competence to proceed, the proceedings shall be resumed.

B. If the court is of the opinion that by reason of the passage of time and its effect upon the criminal proceedings it would be unjust to resume the prosecution, the court may dismiss the charge and order the person discharged.

§ 7100.4.3. Hearing and Determination of Criminal Responsibility.

§ 7100.4.3.1. Determination by the Court.

A. At a hearing under Section 7100.4.2. of these regulations the court may, in its discretion, also hear evidence on whether the person was criminally responsible for the commission of the crime charged. Such evidence shall be heard in accordance with the rules governing the consideration and determination of such issues at a criminal trial.

B. If the person is found by the court to have lacked criminal responsibility, an acquittal shall be entered. If the person is not so acquitted, he or she may raise the defense at such time as he or she may be tried.

C. At a hearing under Section 7100.4.2. of these regulations, a psychiatrist appointed by the court may be called as a witness by the attorney for the Commonwealth or by the defendant and each party may also summon any other psychiatrist or other expert to testify.

§ 7100.4.3.2. Determination at Trial.

A. Upon trial, the court, in the interest of justice, may direct that the issue of criminal responsibility be heard and determined separately from the other issues in the case and, in a trial by jury, that the issue of criminal responsibility be submitted to a separate jury.

B. Upon a request for bifurcation, the court shall consider the substantiality of the defense of lack of responsibility, its effect of bifurcation upon the probability of a fair trial.

§ 7100.4.4. Examination of Persons Charged with Crime as Aid in Sentencing.

§ 7100.4.4.1. Application.

Before a person who has been criminally charged is to be sentenced, the court, on its initiative or upon the application of the attorney for the Commonwealth, the person charged, his or her counsel, or any other person acting in the person's interest, may defer sentence and order an examination for mental illness to aid in the determination of disposition.

§ 7100.4.4.2. Examination.

If at the time of sentencing the person is not in detention, examination shall be on an outpatient basis unless inpatient examination for this purpose is ordered pursuant to the provisions of Section 7100.3 *et seq.* of these regulations.

§ 7100.4.5. Court-Ordered Involuntary Treatment Following a Determination of Incompetency, or Acquittal by Reason of Lack of Criminal Responsibility, or in Conjunction with Sentencing.

§ 7100.4.5.1. Procedure.

Upon a finding of incompetency to stand trial under Section 7100.4.2 of these regulations, after an acquittal by reason of lack of responsibility or after examination in aid of sentencing under Section 7100.4.3, the attorney for the Commonwealth, acting on his or her own or at the direction of the court, the defendant, his or her counsel, the Administrator, or any other interested party may petition the same court for an order directing involuntary treatment under Section 7100.3.4 of these regulations.

June 12, 1978

Follow-up Response - Institutionalized
Juveniles v. Secretary of Public Welfare

1. *Who Is Involved?*

All juveniles committed as mentally ill to mental health facilities in Pennsylvania who are under the age of fourteen.

2. *Procedures To Be Used:*

A. *Probable Cause Hearing:*

A hearing must be held within 72 hours of detention to determine whether there is probable cause for the institutionalization of the juvenile.

B. *Full Commitment Hearing concerning the need for commitment must be held within two weeks of admission.*

C. *Notice:*

1) *Prior notice of the date, time, and place of the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment must be received by the juvenile and the juvenile's attorney within 48 hours prior to the initial hearing.*

2) *This notice must also be sent to the clerk of the court with jurisdiction which will be forwarded to the juvenile's attorney until the legislature establishes some other procedure consonant with the opinion and order of this decision.*

D. *Counsel:*

1) *The juvenile has the right to counsel or other trained representative during all stages of the commitment procedure.*

2) *If the juvenile is indigent, an attorney or other trained representative will be provided free.*

E. *Presence of the juvenile at all commitment hearings, opportunity to be heard, cross-examination of adverse witnesses, and the opportunity to offer testimony of witnesses and other evidence on the juvenile's behalf.*

F. There must be clear and convincing proof for the need of institutionalization.

G. 1) Excepting the rights to notice and to counsel, with the approval of the juvenile's attorney and the finding that the juvenile understands his rights, the juvenile may waive his rights.

2) Where the juvenile does not understand his rights or is incompetent to waive them, the juvenile's attorney may do so, excepting the rights to notice and to counsel.

3. Are the MH and MR Hearings to be different; if so, how?

Procedurally, the hearings are the same. Substantively, the evidence required to establish the need for treatment in a mental health facility or habilitation in a mental retardation facility will depend on the requirements outlined in applicable law.

4. Are there existing procedures which can be used?

Yes, the procedures as outlined in the Mental Health Act of 1976, i.e., Act 143. These procedures would need only minimal modification to conform to the court order.

COMMONWEALTH OF PENNSYLVANIA
GOVERNOR'S TASK FORCE ON THE MENTAL HEALTH
OF
JUVENILE OFFENDERS

INITIAL MEETING - JUNE 21, 1978 - NOON

GOVERNORS' RECEPTION ROOM

AGENDA

I.	Presentation of Task Force Members To Governor Shapp	Milton Berkes Special Assistant to the Governor for Human Services
II.	Charge To The Task Force	Milton J. Shapp Governor
III.	Review of Information and Operating Procedure	Robert P. Haigh Deputy Commissioner for Mental Health
IV.	Summary of Current Status of Mental Health Services to Adolescents	H. Allen Handford, M.D. Director, Children & Youth Services Office of Mental Health
V.	Highlights of Study on Mental Health Services in Youth Development Centers	Harold Graff, M.D. Office of Mental Health Liaison to Youth Development System
VI.	Schedule of Meetings, Selection of Chairman and Other Issues	

II. CURRENT STATUS of MENTAL HEALTH PROBLEMS AND YOUTH

Harold Graff, M.D.
July, 1977

MENTAL HEALTH PROBLEMS WITHIN THE YOUTH DEVELOPMENT CENTERS COMMONWEALTH OF PENNSYLVANIA

Purpose

The purpose of this report is to describe the current status of mental health problems and the ways they are handled within the Commonwealth's System of Youth Development Centers. The desire for such a survey came from several sources. The writer was approached by Dr. Allen Handford in March, 1977 about the concerns of the Department of Public Welfare for such a study. Such concern was voiced by the Deputy Secretary for Mental Health to the writer over his learning that in some instances juveniles within the youth development system were consistenly over-medicated with phenothiazines. It was his desire to learn how much or to what degree the mental health needs of these youth were being adequately served.

The attitude that such a survey was required originated within the Office of Social Services under Deputy Secretary Gerald Radke. The director of the Youth Development System Robert Sobolewich, reported his observation to Mr. Radke and Mr. Paul De Muro on October 27, 1976 on certain therapeutic practices at the Waynesburg YDC that concerned him. While his specific concerns over what he viewed as untoward conditions at Waynesburg catalyzed the department into studying conditions, it was recognized by everyone concerned that a study of the entire Youth Development System would be more productive of problem identification and solution than a specific focus on a single institution. It was this purpose that the writer was commissioned by joint agreement of Dr. Robert Daly and Mr. Gerald Radke to undertake the project presented here.

1. The problem of the emotionally disturbed juvenile delinquent is a real one, and may be increasing

2. The numbers of actually emotionally disturbed adolescents in each YDC is unknown, and there are no valid statistics for the entire system

3. The numbers of recognized emotionally disturbed residents in each individual YDC is cyclic

4. The argument over whether all juvenile delinquents are emotionally disturbed or not should be moot, since it has little to do with the problem being discussed here. The line staff of the YDCs are capable of working with the socialized delinquent. Treatment problems revolve around an entirely separate group of acting out or uncontrollable youth who do not fit into the YDC system

5. In general the staffs of the individual YDCs are well trained and act as competent therapists. They do not have expertise in treating and feel uncomfortable in working with emotionally disturbed adolescents

6. The severely acting out emotionally disturbed resident presents a dissident force in a unit. He takes up too much individual staff time and distracts them from the group. This in itself may generate great resentment from the staff and thus greater acting out

7. Most YDC staff ask for psychiatric help in dealing with emotionally disturbed residents. They mean various things: (1) create a special treatment unit (2) get a better response from the local MH/MR (3) have the state hospital handle the problem (4) get more psychiatric input

8. The way the emotionally disturbed delinquent is treated within the individual YDC depends to the greatest degree on its local staff and their concepts of therapy. Thus in one place drugs may be employed

greatly and in another place minimally. In one place isolation is a major modality and in another place is forbidden. This also depends on the type of psychiatric consultation available.

9. Guidelines for prescribing psychiatric treatment are individualized to the unit YDC. Supervision of psychiatric personnel has not yet been established. Thus drugs may be prescribed in high doses without close monitoring in one YDC, while in another automatic stop orders are the rule.
10. Staffing patterns for psychiatric input vary widely from full time availability to none at all.
11. Positive community response to the mental health needs of the local YDC is felt to be little by the staff, leading to difficulties in dealing with emergencies.
12. The YDC staff has expressed concern over the attitudes of the adolescent units in state psychiatric hospitals towards YDC residents sent for treatment. They would like closer communication between them and the psychiatric unit

Recommendations

These recommendations should be regarded as preliminary and as a first step towards solving a chronic and pervasive problem. They will require discussion and development in order to activate them effectively.

1. An accurate count of the numbers and percentages of emotionally disturbed adolescents in the YDCs must be obtained. The figure is essential for program planning and for deciding the amount of psychiatric input necessary. We are already in the process of looking for ways to begin such a study. Funds might come from an

NIMH grant, from LEAA, or be funded through DPW.

2. Establishment of special psychiatric treatment units within YDCs should not be considered since they may be both counter-productive and create more problems than they can solve. These problems would revolve around (1) staffing problems (2) problems of assignment to the unit (3) increased costs (4) segregation and stigmatization of youth assigned to them (5) loss of peer pressure toward more normal behavior.
3. Liason between the Office of Mental Health and the Office of Social Services should be continued and strengthened, perhaps through creation of a permanent position with support. The position would be utilized to implement the following recommendations.
4. Increasing the amount of psychiatric input for the YDCs that require it. This can be done by making arrangements with qualified local psychiatrists and by working with the area medical schools.
5. Provide inservice training and supervision for psychiatrists who participate in the treatment of the residents. This may also be extended to diagnostic units and community programs. We are already negotiating to provide psychiatric coverage to the Philadelphia YDC from Jefferson Medical College.
6. Establish guidelines for the use of treatment modalities in the YDC system through a well thought out set of regulations to be prepared by the psychiatrists in the system chaired by the liason person.
7. Create better relations with local mental health units in the YDC area for use in emergencies. This would be done by personal contact and discussion.

8. Develop a closer working relationship between state hospital adolescent units and YDCs so that joint planning can be instituted for each problem case. This again may be the designated responsibility of the liason person. This may have to be preceded by visits to state hospital adolescent units to ascertain their capabilities to cooperate in such a program. It is possible that they may have to be assisted to create new therapeutic systems which have been shown to be successful in handling emotionally disturbed acting out adolescents.
9. Each YDC has individual diagnostic and treatment systems which are excellent. Integration of the best of them throughout the system by use of seminars and training should help increase the potentials for accurate diagnosis, development of treatment plans, and organization of methods to carry them out effectively and successfully.
10. Consideration of the establishment of an adolescent forensic mental health center to study emotional problems of juvenile delinquents and test ways of treating them. This would be a research team, not a physical treatment center, which would use grants to study emotional problems of juvenile delinquents, the relationship between the two problems, ways for effective treatment, and other new programs.

Conclusion

The preliminary study of mental health problems of adjudicated adolescents has shown the existence of a large but unnumbered group of emotionally disturbed delinquents. The staff of the system has asked for help in handling them. Recommendations for beginning to understand the problems and to find ways to solve them have been provided.

Harold Graff, M.D.
June, 1977

Director of Liaison Psychiatry to the Office of Social Services

Definition:

This is a highly specialized professional medical and administrative work in adolescent mental health for the Youth Development Centers.

An employee in this class directs a group of psychiatrists and mental health therapists of related disciplines who work to diagnose and treat adjudicated adolescents who are in the Youth Development system. He will work closely with the Deputy Secretary for Mental Health, the Deputy Secretary for Social Services, the Director for Children and Adolescents, and the Director of Youth Services in planning mental health services for the Youth Development Centers. He will organize mental health services, provide for treatment, and supervise disposition of difficult cases. He will work to develop and maintain good working relationships with adolescent units in state psychiatric hospitals, community mental health clinics, and other providers of mental health care. He will plan and direct in-service training for Youth Development Center personnel. Employees in this class will also direct and supervise research that will lead to program improvements.

Examples of Work Performed

Directs and coordinates program planning for mental health in Youth Development Centers.
Serves as a mental health advisor to the Director of Youth Services.
Develops and directs programs for mental health in Youth Development Centers.
Initiates and coordinates studies and surveys for the purpose of reviewing and improving mental health services in the system.
Supervises a highly professional support staff for the programs.
Confers with high level officials of programs, offices and departments concerning programs, administrative planning, improvement and evaluation.
Performs related work as required.

Required Knowledge, Skills and Abilities

Thorough knowledge of the theories, principal, practices, and techniques used in the field of psychiatry.
Considerable knowledge of mental diseases, their symptoms, treatment, and social implications.
Considerable knowledge of adolescent development, mental health, and the emotional problems of adolescence.
Considerable knowledge of how problems of adolescence relate to juvenile delinquency.
Knowledge of theories, techniques and practices of programs and therapies in Youth Development Centers.
Knowledge of legal, forensic, and judicial systems and their relation to juvenile delinquency.
Ability to plan, organize and direct mental health programs for Youth Development Centers.
Ability to exercise judgment and discretion in developing and interpreting objectives and policies governing mental health programs in Youth Development Centers.

Minimal Experience and Training

Four years of clinical experience in professional psychiatry, including specialized work with adolescents, and completion of a three year residency or training porgram which meets the requirements of the American Board of Psychiatry and Neurology.

Necessary Special Requirement

Possession of a license to practice medicine in the Commonwealth of Pennsylvania as issued by the State Board of Medical Education and Licensure.

IV. CURRENT PROJECTS RELATED TO TASK FORCE MISSION

Office of Mental Health - Work Sheet

Children Residing in State Mental Hospitals on June 30, 1978, by Age Group and by Hospital

PROJECT _____ DATE _____

Facility	TOTAL	Age group 0 - 4	5 - 9	10 - 11	12 - 14	15 - 17
Allentown	37	1	20	6	6	4
Clarks Summit	0	-	-	-	-	-
Danville	1	-	-	-	-	1
Dixmont	0	-	-	-	-	-
Embreeville	0	-	-	-	-	-
Farview	0	-	-	-	-	-
Harrisburg	4	-	-	-	1	3
Haverford	21	-	-	6	2	13
Hollidaysburg	0	-	-	-	-	-
Mayview	23	-	9	5	6	3
Norristown	9	-	-	-	2	7
Philadelphia	3	-	-	-	-	3
Retreat	1	-	-	-	-	1
Somerset	4	-	-	-	1	3
Torrance	1	-	-	-	-	1
Warren	12	-	-	-	4	8
Wernersville	1	-	-	-	-	1
Woodville	28	-	-	-	7	21
EPPI	12	1	9	2	-	-
ESS & H	140	-	8	9	62	61
TOTAL	297	2	46	28	91	130

MH 20 - 3-06

ACTIVE CASELOAD AT THE BEGINNING OF THE YEAR BY COUNTY PROGRAM

MH/CHILD&YOUTH TARGET POPULATION

	1973-74	1974-75	1975-76	1976-77	1977-78 1/
S.E.REGION	9,491	9,108	12,871	12,770	13,678
Bucks	1,111	1,451	1,781	1,879	2,116
Chester	166	137	274	446	568
Delaware	2,073	818	801	840	812
Montg.	717	753	868	930	485
Phila.	5,424	5,949	9,127	8,675	9,697
N.E.REGION	1,686	2,350	2,828	2,959	2,969
Berks	133	161	138	204	241
B-S-T	36	84	158	185	180
C-M-P	182	283	303	251	322
L-S-W	227	245	257	315	260
Lehigh	447	264	366	414	679
Luz-Wyo	275	690	736	716	671
Nohamp.	276	462	718	663	443
Schuylk.	110	161	152	211	173
CENTRAL	2,887	3,407	3,925	3,354	3,310
Bed-Som	92	198	175	203	189
Blair	202	179	225	161	181
Cambria	235	251	328	243	228
Centre	34	40	39	50	116
C-M-S-U	104	102	116	154	161
Cumb-Per	125	238	575	416	243
Dauphin	322	157	-	264	408
Fran-Ful	22	64	71	70	71
Hun-Mif-J	150	192	237	183	191
Lancaster	434	445	526	285	277
Lebanon	81	219	219	146	146
Lyc-Clin	66	111	166	177	195
Noumber	60	95	127	43	-
York-Ad	960	1,116	1,121	959	904
WESTERN	6,200	7,973	8,795	8,289	8,927
Allegh	3,012	3,543	3,171	2,454	3,480
Arm-Ind	114	161	241	272	217
Beaver	183	460	922	908	819
Butler	291	299	259	179	136
C-E-M-P	257	339	407	398	432
C-F-V-W	211	187	179	176	159
Cl-Jeff	215	188	207	166	198
Crawfrd	350	524	670	495	372
Erie	425	816	1,049	1,273	1,244
Fayette	144	182	248	333	320
Lawrence	83	155	130	177	120
Mercer	107	109	123	106	95
Wash-Gr	351	485	428	471	436
Westmrl	457	525	761	881	899
ST.TOTAL	20,264	22,838	28,419	27,372	28,884

1/ Preliminary data, subject to change

IV. CURRENT PROJECTS RELATED TO TASK FORCE MISSION

June 7, 1978

SUBJECT: Blueback Contract #547717401
Thomas Jefferson Medical College
Department of Psychiatry and
Human Behavior

TO:

Mr. Gerald Radke
Acting Executive Deputy Secretary

FROM: Allen Handford, M.D.
Director, Children and Youth Services

In response to your memorandum of May 24, 1978 and that of the Secretary of April 3, 1978, the following information is provided on the above named contract:

1) Type of service to be purchased - development of a service delivery system in mental health for clients of State Youth Development Center in DPW Southeastern Region.

2) Reason for purchase of service - lack of a comprehensive, coordinated mechanism for the delivery of mental health services to those juveniles in need who are currently committed to Youth Development Centers. Service cannot be provided through existent agency capabilities due to lack of trained personnel, and personnel for coordination and development of service linkages.

3) Cost of contract - this is not a contract renewal, but a new contract with a budget scaled down in cooperation with the Office of Social Services (Mr. Horace Lowell).

4) Basis on which the cost of the contract was determined - Cost was based on program funding.

5) Consequences to client or program operations if contract is not approved - Mental Health services will not be coordinated and delivered and clients will go unserved.

6) Mr. Colautti's memorandum points:
   1. The current need for the contracted service. There is an urgent need for the development of effective delivery service system to meet mental health needs of juveniles in Youth Development Center programs. Currently, these needs are not consistently met by the system and such juveniles present serious problems of care in the YDCs.

2. The alternative for providing the service. Because the service crosses system lines between Youth Services and Mental Health there is no current alternative for providing this service. The goal of the contract is to develop linkages so that services in place can meet these needs.

3. Units of cost associated with each contract. Costs have been developed in coordination with the Office of Social Service, consists primarily of staff and are consistent with other public programs.

4. The relative value of the service. These are the other fiscal needs of the Department. Mental health needs of juveniles have a high priority as this population presents some of the most urgent problems in our system.

Should further information on this contract be required, please be in touch with us.

cc: Dr. Daly
Mr. Haigh/Mr. Darney
File

University of Pittsburgh

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
School of Medicine Department of Psychiatry
Division of Child Psychiatry

April 7, 1978

APR 11 1978
D.P.W.
Western
Region

Charles Peters
Administrator
Allegheny County Mental Health
Mental Retardation
Drug and Alcohol Program
901 Allegheny Building
429 Forbes Avenue
Pittsburgh, Pennsylvania 15219

RE: Shuman Center Project

Dear Mr. Peters:

Enclosed is a Progress Report regarding the Neuropsychiatric Assessment and Disposition Service (Shuman Center Project).

This report contains a synopsis of the Project's course to date, and considerations for the future. If you have any questions concerning the information, or if additional information is required, please contact us at any time.

It is prudent to mention that this Project is and always has been considered one part of a larger system of services to youth, proposed by the Allegheny County Juvenile Court, Regional Office of Public Welfare and Mental Health Task Force. As you know, the companion and interdependent services that comprise this system are not yet a reality. The ultimate success and benefits of a professional service such as the Shuman Center Project will be most evident when it functions within a total service continuum. We feel that discussions and efforts towards the realization of the development of the other enabling proposals are of an immediate nature. Our staff is eager to be involved in this effort.

It is hoped that together, planning in this direction could begin in the near future.

Sincerely,

Richard L. Cohen, M.D.
Director of Children's Services

Ake Mattsson, M.D.
Project Director

msc

cc: Ralph Meador, Commissioner of Mental Health, Western Region
Meyer Sonis, M.D., Task Force Staff

3811 O'HARA STREET, PITTSBURGH, PA. 15261
Enclosures - 2

PROGRESS REPORT

A. July 1977 - August 1977: Since July 1, 1977 it was possible to officially begin to 1) recruit staff and 2) to begin meeting with the Shuman Detention Center staff.

During these months, in order not to committ staff and salaries only the Project Coordinator and the Psychiatric Social Worker were on the payroll. No other expenses were incurred during this period. The basic format and development of internal operational guidelines were designed. Discussion concerning the measurements to be used, changes in staffing patterns were made, and an initial series of meetings with the Judicial system was begun. This included meetings with the Administration, Clinical, Judicial, and Probation staffs of the Allegheny County Juvenile Court. These meetings were conducted to meet and learn of the existing programs and procedures of these staffs. These initial meetings also involved the explanation of our service and development of mutually agreed upon methods of operation. These meetings were somewhat limited in progress due to the vacation schedules of the detention personnel, specifically the Judges and part-time psychologists. A clarification of the project's actual functions was necessary as considerable faulty and mis-information concerning the service existed.

B. September 1977 - October 1977: This time period accomplished 1) recruitment of staff - most noteworthy was the arrival of the Medical Director/Program Director in mid-September. Other arrangements were finalized in procuring the medical examinations in conjunction with Children's Hospital of Pittsburgh, and in obtaining a Psycho-educational Diagnostician to conduct educational and psychological testing of the patients.

These two months were used to meet with the Juvenile Court Judges and clinical personnel of the Detention Home. These meetings produced a referral system, and designated criteria for referrals to enter the assessment service. The general content of a final summary report to be forwarded to the Court was also developed.

On September 12, 1977, the In-Service Training and Consultation Component of the project began. Weekly presentations to the direct care staff of the Detention Home, and twice monthly consultative services are provided.

A detailed course outline was developed, and the University of Pittsburgh School of General Studies has granted under-graduate accreditation for the weekly course. The bi-monthly Case Conferences are attended by representatives of all direct care departments of the institution.

C. November 1977 - Present: Since November a total of sixteen (16) cases have been referred to the project. Referrals have been forwarded by each Judge and the Master of the Juvenile Court. The Mental Health personnel of Shuman Center have also referred adolescents for more extensive evaluation or for consultation purposes. Probation officers have referred cases through their administrative channels.

As initial evaluation of the patients proceeded, it soon became very clear that a high percentage of these adolescents required acute care in a

psychiatric setting and/or further intensive evaluation, to include medication trials or professional observation over a controlled period of time. In December 1977, a system for in-patient care and evaluation was developed with the resources of Western Psychiatric Institute & Clinic.

This resource has proven invaluable in properly assessing the current functioning of many of the adolescents. This continued evaluation has allowed for more specific and more appropriate recommendations to be made to the Court. This resource has in addition unquestionably permitted these adolescents to be started on a course of treatment psychiatrically and physically.

Attached is a summary of the findings of the initial referrals.

FUTURE CONSIDERATIONS

A. Development of Monitoring Component - The Task Force of the Allegheny County Juvenile Court, Regional Office of Public Welfare and Mental Health has extensively documented the need for this service. Included in their report, which was adopted by the entire Task Force, is an outline for the implementation of a County-wide monitoring Authority. The scope and purpose of this Authority was to be broad and tasked to monitor the over-all, effectiveness of the regional human services. Included was capabilities to: foster the disbursement of public funds, develop a system of data collection and analysis; to plan human services for unmet needs; to maintain cooperation between public and private sectors of human services.

The monitoring component of our service is not intended to accomplish the above purposes on such a large scale. The basic purpose of this component is to follow the designated juvenile evaluated by our service throughout his course in the various Court ordered programs. Unlike the third enabling proposal written by the Task Force to develop an administrative and evaluatory agency to monitor and plan juvenile programs, our service is designed to be a liason with the other agencies that provide treatment to the adolescents assessed by the service. This aspect of the program will allow for consultation to agencies, interpretation of the assessment when necessary, and re-assessing the child when appropriate.

An integral part of our over-all service is to provide a mechanism for the follow-up of the referred adolescents in order to determine the effectiveness, soundness and practicality of our recommendations for definitive treatment/placement. In addition, this system will allow for the measurement of progress each individual has or has not made. It will enable us, as well as the persons directly responsible for his care, to evaluate the adolescent's current status, and to develop future treatment/placement goals.

A mechanism to operate this component is available within the project files. The monitoring component has always been considered an extremely important feature of the service. However, because of the severe delays in beginning the project it has not been possible to actively institute this necessary element. This aspect of the service is a high priority

for the new fiscal year. It is understood that through this vechicle the immediate effectiveness of treatment recommendations would be better evaluated. In addition, long-term tracking and evaluation is also possible, which will benefit the patient as well as to produce clinical data useful in future planning for aggressive adolescents.

B. Staffing Patterns - the sole additional evaluator to be considered for the project staff is a Vocational Evaluator. Our study of the demonstration referrals indicate the over-whelming disenchantment with the traditional educational systems by the adolescents and the large gap between chronological age and functional school performance. It is apparent that the adolescents would be better suited to enter the vocational training programs available within the community and school system. A vocational assessment of interests and abilities would be an important addition to the total evaluation.

C. Secure Funding Levels - A budget figure for 1978-1979 accompanies this progress report.

D. Development of Companion Enabling Proposals Recommended by the Task Force - The Fask Force of the Allegheny County Juvenile Court, Regional Office of Public Welfare and Mental Health, has extensively documented the need for a Secure Intensive Treatment Facility, and a Planning Monitoring Authority. It is noteworthy that the Task Force strongly recommended the adoption of these programs for the Western Region of Pennsylvania. Specific findings of the Task Force, was well as detailed plans for their implementation have been forwarded to the convening authorities of the Task Force.

The first findings of our demonstration project, although an admittedly small sample, clearly supports the identified need for these proposals to become part of the continuation of human services to the Juvenile population. This is of an immediate nature regarding the Secure Intensive Treatment Facility. A high percentage of our patients would benefit from an interim placement in a professional medical/psychiatric unit for continued evaluation, and the commencement of treatment prodedures. Eleven of the fifteen completed evaluations support the recommendation for a short-term placement for the above purposes. In addition, most if not all of these adolescents may require a structured, secure, residential psychiatric treatment-oriented facility for periods of perhaps up to a year or longer. At the present time, this type of facility does not exist for the aggressive delinquent adolescent. Existing facilities are hesitant to accept these patients and the few that are accepted involve difficult and lengthy procedural planning. In most instances, inappropriate or no beneficial dispositions are arranged for these adolescents.

The authorization of a County (Regional) monitoring authority would allow for rational planning of the "total scope of human services which would be required ultimately for a regional system of human services to the designated juvenile population..." Among the many benefits to be derived from this Authority, would hopefully be the elimination of the above problem of mis-placed youths, as well as the reality of a mechanism to carefully monitor and follow the youth during his placement in the juvenile legal, and mental health systems.

SHUMAN CENTER PROJECT

Presently fifteen referrals to the Neuropsychiatric Assessment and Disposition Service have been accepted of which three are still in the process of being completed. More than half of these patients were currently charged with some type of assault. Four were to stand trial for crimes of a sexual nature, while two youths had been previously charged with this type of crime. Seven of the patients had been involved with a burglary or theft.

Thirteen of the referred cases were male and only two were female. Although the range of ages of the patients is from 12 - 18, 60% of them were either 15 or 16 when they were seen by the project staff. The breakdown in terms of race shows that 9 of the cases were black (60%) and six (40%) were white. The range of the Full Scale IQ scores of our patients varied between 68 and 103. Six patients scored below one standard deviation from the average IQ score.

None of the patients' developmental histories could be characterized as non-stressful. Nine of the cases show family histories of marital problems which led to divorce. Five adolescents were from homes where there has been a parental death. When not institutionalized one third of the patients are not living with their natural parents. Only two of the adolescents seen by the project comes from an intact family. Another indication of the very difficult family background from which these patients come can be seen in the high rate of child abuse and neglect. Five patients or one-third of all the referrals seen by the Assessment Service were subjected to abuse and neglect by family members.

Six of the 15 referrals were made by Judge Johnson to the Service. Judge Wettick made four referrals; Judge Tamilia three and Master Novak two. Twelve of the 15 referrals were made due to the aggressive nature of the patients' behavior and/or for evaluation in regards to disposition. The reasons for the other three referrals all include providing additional psychiatric information and to help the court made sense of previous information received from other sources.

Twelve recommendations have been made so far by the Shuman Center Project. Eight of these recommendations included short term inpatient care at WPIC. Two patients were seen as needing more long term inpatient care at a psychiatric treatment setting. These two were also recommended for trials of medication along with 5 of the patients who were recommended for short term inpatient. Seven children were seen as being able to benefit from placement in a residential facility either immediately or after a short term inpatient placement at WPIC (four cases). Due to their special needs in regards to education, five patients received recommendations that included some type of individual designed educational program. In three cases, counseling was seen as beneficial for the patient and also in three cases if was seen as necessary for their family. Treatment for physical problems were recommended three times. The conditions treatment was considered necessary for include: anemia, hyper-calcemic, obesity, and rheumatic

heart disease. In one case the Project Team felt that the disposition of the child should be entirely in the hands of the legal system.

V. YOUTH DEVELOPMENT AND TREATMENT CENTERS

YOUTH DEVELOPMENT CENTERS

The "YDCs" are open institutions built on the cottage plan; the new institutions house 16 youths in a cottage. Cornwells Heights, New Castle and Warrendale each have one medium security cottage. Each institution has a school on the campus, a central dining hall, a medical facility, indoor and outdoor recreation facilities--including swimming pools in the new institutions, as well as separate administration and maintenance buildings.

The "YDCs" combine treatment with daily living and thus youths live, work, and interact in groups or "cottages" with their own staff team of youth development counselors and houseparents. This staff also maintains contact with the youth's teachers, family, and probation officer. Length of stay is determined by the particular youth's progress, his family, and his community situation. This period usually varies from 4 to 10 months.

Youth Development Centers provide both custodial and rehabilitative services to juveniles in their care. They are designed (a) to protect the community from additional delinquent acts which these youths may commit if allowed to remain in their communities, and (b) to protect the social welfare and to provide safety for these incarcerated youths. In addition, the Centers provide a network of psychological and vocational services aimed at the rehabilitation of the youths through correction of their delinquent behavior.

The primary emphasis of the YDC's treatment programs is one of encouraging and rewarding a youth's efforts at making positive changes in his behavior and personality orientation. Support services available to the youths include social casework, psychological testing and counseling, psychiatric consultation, medical and dental care, and religious counseling by community clergymen. Since the goal of these services is the youth's successful community reentry and sustained non-delinquent behavior, emphasis is also placed on encouraging the youth to develop new or alternate non-delinquent methods of dealing with family, peer, or community pressures which contributed to their delinquent behavior.

Programs at the YDCs vary according to the age and sex of the youths and according to the geographical location of the institution. Since many of the students are of average or dull-normal intelligence, the educational and therapeutic programs are designed accordingly. The programs, however, are not designed to serve youths who have an intelligence quotient lower than 70 or who have severe emotional and physical problems.

The isolated rural location of several of the YDCs has influenced the development of these programs. Of particular concern is the lack of professional, clinical and vocational personnel to meet the specialized needs of the youths. Also, treatment difficulties result from separating the youths so far from their families and communities. In addition, racially balanced staffs cannot be provided by communities in these rural locations.

YOUTH FORESTRY CAMPS

Three residential youth forestry camps are currently in operation, located in Carbon, Huntingdon and Beaver counties. Admission is limited to boys between the ages of 15 and 18. Although in the past these camps have had a program that was primarily work related in nature, in recent years there has been a shift to a more treatment oriented type of program. As a result, while some conservation work in cooperation with the Department of Environmental Resources still continues, more emphasis is placed on vocational, educational and therapeutic programs. Youngsters are frequently placed in treatment on job locations in communities surrounding the individual camps.

DEFINITION - DAY TREATMENT CENTERS

A Day Treatment Center is a non-residential facility which can offer a variety of programs for delinquent or deprived youth. Youngsters who participate in the program may also be housed in residential centers, but these centers should be totally separate from the Day Treatment Center and should be licensed under the appropriate regulations for the particular type of residential component. Typically, Day Treatment Centers operate either on an 8-hour or 12-hour basis. Some programs are designed as alternative schools running from 9 a.m. to 3 p.m., with a traditional type of school program and then moving into counseling, recreational and other forms of specialized activities in the late afternoon. The 12-hour Center generally follows this pattern but includes as well an evening program.

Currently operating in Pennsylvania we have Day Treatment Centers which operate from 9 a.m. to 6 p.m., 5 days a week; 9 a.m. to 6 p.m., 7 days a week; 9 a.m. to 9 p.m., 5 days a week; and 9 a.m. to 9 p.m. 7 days a week. Some of the facilities have all of their programs within a single physical location, providing school, recreation and counseling at that site. Others maintain a physical location but use that as a base of operations. Children may attend school in the community or may have jobs and the Day Center becomes a central coordinating point, a place for recreation, counseling and a focal point.

The above definition is extremely broad to allow potential service deliverers to design programs matched to the particular needs of their prospective client population and the communities in which they are located. The one aspect that must be watched is that a residential facility which may desire to establish a Day Treatment Center program must be able to prove that the day treatment center program is in fact a totally separate entity and does derive

most of its clients from outside of the institutional residential component. Generally, Day Centers would be used as alternatives to institutionalization, as a condition of probation, or as a treatment plan for youngsters who are deprived. It is also generally assumed that the prohibition against mixing delinquents and deprived in residential facilities, as described in the Juvenile Court Act, would not apply to Day Centers.

RS:pd
4/8/77

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF YOUTH SERVICES

State-Owned

Youth Development Center
at Cornwells Heights
3701 Old Trevose Road
Cornwells Heights, Pa. 19020
(Bucks County)
Telephone: 215-671-4000
Network: 373-3203
Capacity: 96 Residential Male
Director: Charles Nallen

Youth Development Center
at Loysville
R. D. #1
Loysville, Pa. 17047
(Perry County)
Telephone: 717-789-3841
Network: 466-2222
Capacity: 88 Male Residential
77 Male Community

Youth Development Center
at New Castle
R.D. #6, Frew Mill Road
New Castle, Pa. 16101
(Lawrence County)
Telephone: 412-658-3701
Network: 686-7203
Capacity: 168 Male Residential
10 Community Residential (Male)
9 Foster Care Male

Youth Development Center Complex
at Philadelphia
151 Luzerne Street
Philadelphia, Pa. 19140
(Philadelphia County)
Telephone: 215-456-5905
Network: 335-6568
Capacity: 60 Male/Female Residential
140 Male/Female Community
200 Day Treatment Center Male
Director: James Jackson

Youth Development Center
at Warrendale
Warrendale, Pa. 15086
(Allegheny County)
Telephone: 412-776-1561
Network: 645-7501
Capacity: 22 Male Diagnostic/Backup
10 Male & Female Community
Residential
120 Male Day Treatment Center
15 Community Based Diagnostic

Youth Development Center
at Waynesburg
R.D.#1, Waynesburg, Pa. 15370
(Greene County)
Telephone: 412-627-8101
Network: 678-4519
Capacity: 96 Female; 48 Male Residential
Director: Mrs. Gloria Gugliotta

Youth Forestry Camp #1
Raccoon Creek State Park
R.D. #1, Hookstown, Pa. 15050
(Beaver County)
Telephone: 412-899-2906
Capacity: 52 Male Residential
Director: Ricardo Coles

Youth Forestry Camp #2
Hickory Run State Park
White Haven, Pa. 18661
(Carbon County)
Telephone: 717-443-9524
Capacity: 52 Male Residential
Director: Ernest Powell

Youth Forestry Camp #3
Trough Creek State Park
R. D. #1, Box 175
James Creek, Pa. 16657
(Huntingdon County)
Telephone: 814-658-3492
Capacity: 26 Male Residential
12 Male Encounter Four
Director: Ronald Kissinger

mh
10/21/77

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF YOUTH SERVICES

State-Supervised Institutions

Berks County Boys' Home
821 Schuylkill Avenue
Reading, Pa. 19605
(Berks County)
Telephone: 215-373-6456
Capacity: 25 Male
Superintendent: Mr. Lee Schultz

Gannondale School for Girls
4635 East Lake Road
Erie, Pa. 16511
(Erie County)
Telephone: 814-899-0648
Capacity: 48 Female
Superintendent: Sister Mary Teresa, ACSW

George Junior Republic in Pa.
P.O. Box 471
Grove City, Pa. 16127
(Mercer County)
Telephone: 412-458-9330
Capacity: 285 Male
Director: Pat J. Farrone

The Glen Mills Schools
Glen Mills Road
Glen Mills, Pa. 19342
(Delaware County)
Telephone: 215-459-0934
Capacity: 70 Residential
40 Day Treatment Center
Executive Director: Cosimo Ferrainola

New Life Boys Ranch, Inc.
Harleysville, Pa. 19438
(Montgomery County)
Telephone: 215-287-7884
Capacity: 45 Male
Executive Director: Bertram Christman

St. Gabriel's Hall
P.O. Box 390, Pawlings Road
Phoenixville, Pa. 19460
(Montgomery County)
Telephone: 215-247-2776
Capacity: 176 Residential
200 Day Treatment
Director: Brother Richard Mynehan

Sleighton School
Darling Post Office
Delaware County, Pa. 19063
(Delaware County)
Telephone: 215-459-8000
Capacity: 90
Executive Director: Mrs. Gloria Levister

mh - 10/21/77

VI. A PLAN FOR FORENSIC MENTAL HEALTH SERVICES in PENNSYLVANIA-DECEMBER 1977

"... One of the most serious problems facing the Commonwealth is the provision of adequate treatment [illegible] mentally ill [illegible] This is the group [illegible] the criminal justice system and the mental health system [illegible]

A PLAN FOR FORENSIC MENTAL HEALTH SERVICES IN PENNSYLVANIA

Report of
the Governor's Task Force
on Maximum Security
Psychiatric Care

Robert M. Fishman, Esq.
Executive Director

COMMONWEALTH OF PENNSYLVANIA

GOVERNOR'S TASK FORCE ON MAXIMUM SECURITY
PSYCHIATRIC CARE

TELEPHONE
AREA CODE 717, 783-5132

December 1, 1977

The Honorable Milton J. Shapp
Governor
Commonwealth of Pennsylvania
Harrisburg, Pennsylvania 17120

Dear Governor Shapp:

On behalf of the Task Force on Maximum Security Psychiatric Care, I submit to you our final Report.

Considerable effort has gone into the development of the proposed plan for a forensic mental health system in Pennsylvania. The Task Force has worked diligently and applied itself with unusual dedication in addressing the problems to which your Executive Order directed us.

Many individuals offered us support and help during these past eight months which have made our deliberations possible and fruitful. We believe this Task Force Report represents the best thinking the Commonwealth can produce in the area of providing forensic mental health services.

We look forward to your response and are hopeful that Pennsylvania will become a leader in forensic mental health.

Respectfully submitted,

Paul A. Dandridge

Judge Paul A. Dandridge
Chairman

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i. OVERVIEW OF THE TASK FORCE'S REPORT

This document contains the findings and recommendations of the Task Force established by Governor Shapp to review the current status of Maximum Security Psychiatric Care in Pennsylvania and to make recommendations concerning the steps the Commonwealth should take to ensure the provision of the best possible care for the mentally ill offender who requires treatment in a maximum security setting.

After reviewing the current status of maximum security psychiatric care in the Commonwealth and in other states, as well as the legislative, judicial and executive mandates under which such treatment must be provided, the Task Force's recommendations concerning the development of a forensic mental health care system are presented. These include:

1. Establishment of a comprehensive Forensic Mental Health System consisting of the following components:

   (a) Outpatient and diagnostic mental health services within State prisons.

   (b) Multi-level secure inpatient forensic units at selected State hospitals.

   (c) Crisis intervention, preventive, and aftercare services within the county jails.

   (d) County court diagnostic clinics.

2. The closing of Farview State Hospital by the end of 1980.

3. The establishment of interagency committees to plan and implement the proposed system.

4. The establishment of a forensic information system.

5. Creation of a central staff for forensic services within the Office of Mental Health.

6. The establishment of comprehensive forensic mental health services for women.

7. The establishment of a task force to address the psychiatric needs of juvenile offenders.

8. The establishment of a mechanism for voluntary commitment of mentally ill offenders.

9. Continued application of Act 143 in prisons.

10. The funding, by the Commonwealth, of forensic mental health services.

11. Consideration, by the state, of ways to offset the adverse economic effects to Wayne County of closing Farview State Hospital.

12. The involvement of the public, legislators, judges and other members of the legal system, and mental health administrators and groups in the planning and implementation of the Task Force's recommendations.

ii. ACKNOWLEDGEMENTS

Several people and administrative units provided special assistance to the Task Force. Polly Smith of the American Foundation, Institute of Corrections, researched the existing forensic psychaitric services within prisons and mental health facilities of twelve states. Andrea Jacobsen, Esquire and Jack Handler, Esquire of the Department of Justice, provided legal assistance and rendered opinions in several areas. Melvin Heller, M.D. of the Office of Mental Health, discussed many of the problems now existing in mental health care to prisoners and pointed out many complex issues that must be addressed in designing a forensic mental health system.

The participation of key persons from the Bureau of Correction and the Office of Mental Health greatly aided the Task Force's efforts. Both Commissioner Robinson and Ray Belford, Ph.D. provided helpful observations and data. Deputy Commissioner Robert Haigh and Ralph Phelleps provided information about the procedures and operations of the forensic components of mental health. Considerable administrative and clerical support was given by the Office of Mental Health. Special thanks go to Margaret Underkoffler for her handling of the organizing and clerical details.

In addition, the Task Force received helpful input from the many people who testified at the three public hearings. (Appendix I)

I. INTRODUCTION

A. The Governor's Executive Order

Governor Shapp in his Executive Order of March 29, 1977, established the Task Force on maximum security psychiatric care, and charged it to address the problems facing the Commonwealth in providing treatment in a secure setting for the mentally ill offender.

The specific responsibilities included in the Governor's charge to the Task Force were to:

a. review in depth the past and present history of Commonwealth programs to provide maximum security mental health treatment.

b. review the legislative, judicial, and executive direction which has been given to such treatment in the past.

c. survey innovative approaches which other states have used to meet this special need.

d. establish for the present, and project for the next ten years, the maximum security care service needs in Pennsylvania.

e. review the presently existing plans regarding Farview and the Forensic Mental Health System.

f. make specific recommendations regarding legislative and executive actions necessary to meet the need for maximum security mental health services in Pennsylvania.

g. make specific recommendations on where and how such services should be provided in Pennsylvania.

h. submit recommendations concerning a course of public education necessary to effectively implement the recommendations of the Task Force.

i. report its findings and recommendations to the Governor on or before October 1, 1977, and thereafter cease to function. (Governor Shapp acting on the request of Judge Dandridge extended the life of the Task Force to December 1, 1977, by amendment to the Executive Order on October 14, 1977.)

B. Task Force Membership

As defined in the establishing Executive Order, the Task Force was comprised of the following membership:

Mr. Louis Aytch
Superintendent, Philadelphia Prisons

The Honorable Albert Biele, M.D.
Member, Pennsylvania Board of Pardons

Mr. Harry Boyer
President, Pennsylvania AFL-CIO

The Honorable Paul A. Dandridge
Common Pleas Judge, Common Pleas Court of Philadelphia

The Honorable D. Donald Jamieson
Former President Judge, Common Pleas Court of Philadelphia

Mrs. Marilyn Kanenson
Vice Chairman, Pennsylvania Mental Health/Mental Retardation Advisory Committee

Mrs. Patricia McGrath
Director of Special Programs, The Easter Seal Society for Crippled Children and Adults of Pennsylvania

Mr. William Nagel [1]
Director, American Foundation of Corrections

The Honorable Michael A. O'Pake
Pennsylvania Senate, Berks County

The Honorable Laurel Rans
Member, Pennsylvania Board of Pardons

Donald Reihart, Esquire
York County District Attorney

Robert Sadoff, M.D.
Clinical Associate Professor of Psychiatry, University of Pennsylvania School of Medicine; Lecturer in Law, Villanova University School of Law

The Honorable Anthony J. Scirica
Pennsylvania House of Representatives, Montgomery County

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[1] *Resigned subsequent to the naming of the Task Force due to previously made commitments.*

Herbert Thomas, M.D.
Adjunct Professor of Psychiatry & Law, University of Pittsburgh School of Law; Clinical Professor of Psychiatry, University of Pittsburgh School of Medicine; Editor of Bulletin of American Academy of Psychiatry & Law

The Honorable Edmund V. Ludwig [2]
Common Pleas Court of Bucks County, Judge
Chairman, Mental Health Committee, Pennsylvania State Conference of State Trial Judges.

Ex-Officio members of the Task Force were:

The Honorable Robert P. Kane
Attorney General

The Honorable Frank S. Beal
Secretary of the Department of Public Welfare

Robert M. Daly, M.D.
Commissioner of Mental Health

Governor Shapp asked Judge Dandridge to serve as chairman.

Mr. Robert Fishman was named Executive Director. In this capacity he aided the Task Force in its varied activities and researched issues identified as important.

The Task Force held its first meeting with the Governor on March 29, 1977. Its charge was interpreted as going significantly beyond the problem of providing mental health treatment to prisoners, and touched upon a myriad of legal, constitutional and social issues not readily resolvable. The problem of providing mental health services to offenders and detentioners is multifaceted and to be effective, such services require coordination and cooperation between the Departments of Public Welfare and of Justice, the Bureau of Corrections and often the judiciary.[3] Present services provided through State and local governments are limited; nonetheless it was felt that the design of an effective workable system is possible, and this became the principal goal of the Task Force. Early in the discussions, it became apparent to members that the Executive Order required addressing not only the need for maximum security psychiatric care, but consideration of the entire forensic psychiatric system. The demand, location and delivery of maximum security psychiatric treatment is directly affected, for example, by the existence of prison mental health services, and other secure psychiatric facilities, (e.g., medium secure forensic units). A forensic mental health system was defined by this Task Force as encompassing all units providing mental health services to detained or convicted individuals within the criminal justice system.

The Task Force took a series of actions prior to developing this report; it held a number of full day sessions; reviewed documents prepared by various members and staff; visited Farview State Hospital; conducted a demographic survey of the Department of Public Welfare's forensic units; analyzed the availability of prison mental health services in State correctional institutions; conducted public hearings in Philadelphia, Harrisburg and Scranton; reviewed submitted written testimony from a wide spectrum of individuals, including psychiatrists, psychologists, judges, social workers, patients, and the public; obtained and reviewed a variety of statistical data; and reviewed summaries of forensic systems in other states. (See Figure 1 on the following page for a diagrammatic representation of the Task Force.)

The issue of mental health services for juvenile offenders was raised. The Task Force decided to defer considering this question because of its complexity and the relatively short life of the Task Force. Presently, the Pennsylvania juvenile justice system, which is operated in part by the Department of Public Welfare and in part by the counties, offers minimal mental health services.

The Task Force deferred the issue of addressing the problems of providing maximum security settings for civil patients.

II. THE EXISTING SYSTEM

A. History, Past Practices and Forensic Services

As in other states, the delivery of public-sector forensic psychiatric services in Pennsylvania has been undergoing change reflective of increasing legislative, judicial, professional and public attention to patients' rights, due process considerations, involuntary treatment, and the needs of mentally ill persons involved with the criminal justice system.

In the past twenty years Pennsylvania has come a long way. Up to the 1950's the Commonwealth had a lunacy commission whose function was to examine patients, determine if they had criminal tendencies and transfer them to Farview indefinitely. Under the Barr-Walker Act (later held unconstitutional), a sexual offender could be committed indefinitely to Farview or other State hospitals.

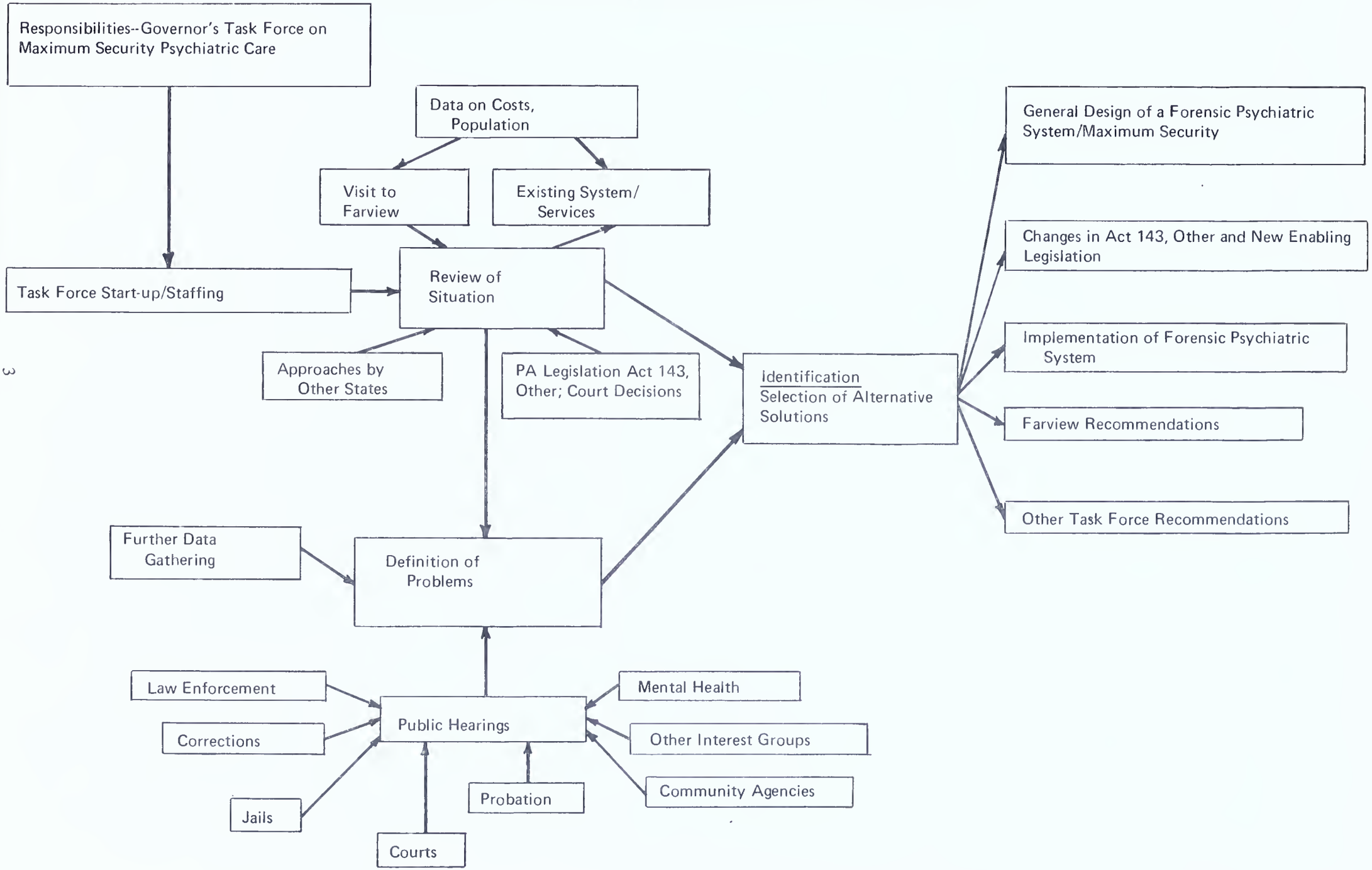
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[2] *Appointed subsequent to the Executive Order.*

[3] *Although two agencies, the Department of Public Welfare and Department of Justice, Bureau of Correction , have primary roles, a variety of other groups are involved in this process: police, mental health units, judges, The Board of Probation and Parole, the community and mental health professionals.*

Figure I

DIAGRAMMATIC REPRESENTATION OF THE ACTIVITIES OF THE GOVERNOR'S TASK FORCE ON MAXIMUM SECURITY PSYCHIATRIC CARE



The history of the disposition of mentally ill offenders and defendants indicates a number of practices pertaining to both civil and criminal commitments, which now seem questionable. These include the mixing of civilly and criminally committed persons in State mental hospitals, and the retention of persons at the expiration of their sentence without adequate review on the assertion that they were mentally ill or dangerous. Wide use of these and similar procedures across the country led to such cases as Baxstrom v. Herold,[4] Jackson v. Indiana,[5] and Dixon v. the Attorney General of the Commonwealth of Pennsylvania.[6] It is telling testimony as to conditions in Pennsylvania that one of the Dixon findings was: "At the time the complaint was filed the medical staff at Farview consisted of the superintendent who is a psychiatrist, and five physicians, none of whom has had psychiatric experience before joining the Farview staff and none of whom had attained professional recognition as a psychiatrist."

In the mid 1960's the Legislature reviewed correctional system needs and authorized construction bonds to construct a maximum security medical and psychiatric center for mentally ill prisoners as part of that system, in or near Philadelphia. There was much resistence on the part of the communities in Southeastern Pennsylvania and no action was taken to construct a new facility there.

"Court-Units", which provide diagnostic workups and brief psychiatric treatment, were in limited operation at State hospitals such as Philadelphia, Norristown and Warren. Because of the special needs and the volume of service in Philadelphia, the Department of Public Welfare entered into a contract in 1966 with the City and Temple University to provide psychiatric services at Holmesburg Prison. Originally envisioned as a temporary measure, the contract was renewed each year for ten years. The Department of Public Welfare is moving toward a January 1, 1978 allocation to the city of Philadelphia which plans to contract with the Department of Mental Health Sciences of the Hahnemann Medical College to provide for the mental health needs of persons in Philadelphia prisons.

Short-term treatment of sixty-day court-committed cases, and mentally ill prisoners referred from the general prison population, have resulted in many hundreds of persons improving sufficiently after a four to six week stay on C Block[8] to be able to return to the general prison population, and proceed with their charges. The best estimates[9] are that, if this service had not been available, it would have been necessary to transfer to Farview State Hospital each year an additional 600-800 individuals requiring psychiatric hospital treatment and maximum security.

The crowded and marginal conditions in the Philadelphia County Prisons have resulted in a number of court-ordered changes following the judicial mandate in Jackson v. Hendricks.[10] In the past six months the City of Philadelphia has moved toward complying with Court mandates under the supervision of a Court-appointed Master. Furthermore, in the pending case of Green v. Soffer, an action was brought against the County Mental Health Commissioner to provide essential psychiatric services for untried mentally ill defendants held in the Philadelphia County Prison System.

Problems in providing emergency and short-term psychiatric treatment to mentally disabled offenders and defendants awaiting trial in county jails exist throughout the Commonwealth. In the past years Farview State Hospital stood ready to receive and hold any and all defendants, and to function as the primary statewide security facility for courts throughout the Commonwealth. Although Philadelphia, Bucks and Allegheny Counties have had psychiatric "Court Clinics" funded by and associated with the criminal courts, the less populated counties often require special arrangements in order to provide adequate diagnosis and treatment for mentally ill offenders and defendants. Urban areas often have greater need to establish court clinics and are better equipped to do so than rural areas. It is suggested that, where needed, counties join together to establish joint endeavors to provide adequate diagnosis and treatment for mentally ill offenders and detentioners.

In 1973 and 1974 separate wards were designated for the development of regional forensic units at the State hospitals at Mayview, near Pittsburgh; Warren, near Erie; and Norristown, near Philadelphia. Philadelphia State Hospital's Court Ward continued to function as a forensic ward, but was not specifically designated a regional forensic hospital facility. Additional attempts to establish forensic units at Clarks Summit and Danville State Hospitals met with overwhelming community and political resistance. The Department continued to review the question of the use of Farview and in 1975 Dr. Melvin Heller submitted a proposal which was widely circulated but not implemented at the time as other considerations emerged.

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[4] *383 U.S. 107 (1966).*

[5] *406 U.S. 715 (1972).*

[6] *323 F. Supp. 966 (1971).*

[7] *Currently, construction of a new 100-bed medical facility (50 psychiatric beds) at Holmesburg is in progress. This unit will replace the cell block presently being utilized and is expected to open in October of 1978.*

[8] *C Block is the State maximum security diagnostic facility at Holmesburg Prison.*

[9] *Office of the Superintendent, and Chief of Psychiatric Services, Philadelphia County Prison System - personal communication.*

[10] *457 Pa. 405 321 A2d 603 (1974).*

Presently constituted regional forensic units have not been able to develop sufficient clinical facilities or security safeguards to cope with mentally ill offenders and detentioners. Moreover, some individuals are currently held under unsatisfactory conditions in behavioral adjustment units in State penitentiaries, awaiting transfer to facilities for the treatment of mentally ill sentenced offenders. Many overtly psychotic, but not necessarily "severely mentally disabled" offenders as defined by Act 143 do not constitute candidates for involuntary commitment to State hospital facilities. Others, for whom "clear and present danger" is distinctly met as a criterion for involuntary commitment remain in behavioral adjustment units as an alternative to Farview. (See Appendix II, "Forensic Units–Current Staffing and Census," for the bed capacity, security rating, recent census and staffing patterns at the regional forensic units at Norristown, Warren and Mayview and the Court Ward (N-8) at Philadelphia State Hospital.)

Norristown State Hospital has a medium security capacity of 75 beds, and in addition, operates another 10-12 forensic beds for persons who require less secure management. Because of its proximity to universities and referral centers, the forensic unit at Norristown benefits from the consultative services of academically affiliated psychiatrists.

Mayview State Hospital's forensic unit has a current capacity of 56 beds for mentally ill offenders and defendants, and also benefits from its relative proximity to the Pittsburgh area, as well as from the special interest of Mayview's superintendent in forensic psychiatric issues. The communities surrounding Mayview continue however to have concerns about the location of a forensic unit at the facility.

Warren State Hospital has a regional forensic unit of 30 beds. While the professional staff at Warren State Hospital is a considerable asset to the forensic unit, additional professional staffing is needed. This problem is, however, not unique to this institution. None of the Commonwealth's forensic units has been successful in recruiting a full complement of qualified psychaitrists.

Philadelphia State Hospital's Ward N-8 has 44 forensic beds. This unit has remained a physically limited facility which has provided services for a relatively small fraction of the diagnostic and treatment needs of Philadelphia's mentally ill offenders and defendants.

In addition to its previously described functions, the forensic unit at Holmesburg Prison provides emergency psychiatric services and treatment for several thousand Philadelphia prisoners each year, many of whom would require commitment to State hospitals were these services not available within the county prison system.

The Office of Mental Health presently has a forensic staff of two, which has provided liaison consultative services with prosecutors, members of the defense bar, the Defender Association, individual courts, and a variety of academic colleagues and community agencies concerned with the criminal justice and mental health systems. Liaison services have also been provided to the Bureau of Correction for a number of mentally ill prisoners recently returned from Farview.

The present mental health services delivery system in Pennsylvania is composed of three major subsystems which are interrelated, though not fully integrated; that is, the County, State and Private Mental Health Systems. The primary legal base for the public program is the Mental Health and Mental Retardation Act of 1966, which charges the Department of Public Welfare (DPW) with the duty "to assure within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them, regardless of religion, race, color, national origin, settlement, residence, or economic or social status."

Under the Act, DPW is responsible for the operation of 19 State Mental Hospitals and one research and training institute, while the 41 community-based administrative units located in the Commonwealth's 67 counties are responsible for community Mental Health/Mental Retardation services. Mandated mental health services include short-term inpatient, outpatient, partial hospitalization, emergency services, consultation and education, aftercare, rehabilitative and training services, and information and referral services. These services must be available to the residents of each of the 86 catchment areas of the County Mental Health/Mental Retardation Program Units.

The county and institutional subsystems are organizationally encompassed under the Department of Public Welfare's Office of Mental Health, the unit responsible for Statewide development of mental health policy. Its responsibilities include program and budget analysis, planning, program evaluation, and the identification of mental health system needs; program policies and recommendations for regulatory and legislative changes; recommendations for approval by the Secretary of DPW of program plans and the allocation of State funds; and development of State plans. Four regional offices have also been developed in order to decentralize operational responsibilities.

Each catchment includes a Base Service Unit which serves as the unified intake agent for the program, which provides for the development of a comprehensive treatment plan and which is responsible for continuity of care, the maintenance of records, and appropriate monitoring of collaborative planning with State facilities. The County Mental Health/Mental Retardation Program is responsible for providing direct services as well as consultation and educational assistance, including preventive services, to its community.

Each of Pennsylvania's 67 counties contains one county prison or jail, with the exception of the city/county of Philadelphia, which has three major institutions. The administration and control of the jails vary widely according to the county classification, and numerous special legislative acts.

Thirty-six (36) counties are designated as 6th, 7th and 8th class; twenty-seven (27) are 3rd, 4th and 5th; two are 2A; one (1) is 2nd class and Philadelphia is the only first class county. The jails in 6th, 7th and 8th class counties are administered by a Sheriff whose governing board consists of the county commissioners. Two of these jails are used only as detention facilities, by agreement with the Bureau of Correction, with a 72-hour time limit. Their prisoners are then boarded out to adjoining counties. Few of the jails in these counties have the capability of providing anything but minimal treatment services for inmates. Generally,. psychiatric services are obtained from local community mental health centers on an "as needed" basis. However, because of the current practices and interpretations of Act 143 and the reluctance of base service units to accept offenders, county jails are forced to deal directly with mental illness.

Counties of the 2A, 3rd, 4th and 5th classes are administered by an appointed warden and governed by a County prison board, the structure of which is set by statutes and special acts. Although many of these county jail facilities have professional staff who can identify patients with mental illness and deal with them to some degree, none of them can provide treatment in a hospital setting within the prison. They incur enormous costs for providing hospitalization and for guarding prisoners who are hospitalized.

Allegheny County Prison has a full-time psychiatrist and a psychologist through the auspices of the Allegheny County Behavior Clinic. They also have the services of volunteers in the mental health area.

B. Security Definitions

The Task Force's responsibility to "project...the maximum secure care service needs for Pennsylvania" presumes a clear definition of the phrase "maximum security". Similarly, the requirement of Act 143 that treatment of a prisoner in the mental health system "not affect the conditions of security required by his criminal detention or incarceration" presumes that both Mental Health and Corrections share concepts of security classifications. Unfortunately, no such uniformity exists. The Task Force has drawn upon the definitions and criteria used by both systems to formulate a working concept of what is maximum, medium and minimum security as it relates to psychiatric treatment, who requires or needs secure placement, and who is to determine the extent of such security in specific instances.

1. Mental Health Security Ratings

The Secretary of the Department of Public Welfare is responsible for designating the security rating of each mental health facility.[11] No official, written criteria for establishing such ratings exist. According to a spokesman for the Office of Mental Health, the following operational descriptions are currently in use:

a. A maximum security mental health facility is a self-sustaining, free standing unit so designed as to minimize escapes. Movement within a ward is monitored but unregulated whereas all other movement within the facility is by escort only. Staff for such a facility must be of sufficient size and have sufficient training to control and treat patients. The ratio of staff to patients should be greater than that in a medium security facility and should approach one-and-a-half to two to one. In addition to virtually eliminating the possibility of escape, a maximum security facility must insure the safety of patients from their own or others' violent behavior.

b. A medium security mental health facility is a unit with locked wards and sufficient security to permit outside recreation. Movement between wards is monitored. Ground privileges and home visits are granted with court approval. Staffing is at a ratio approaching one to one-and-a-half to one patient. Areas within the facility vary as to amount of supervision and usage of physical restraints.

c. There is no minimum security classification for mental health facilities. Cases not committed to medium or maximum security facilities are committed to the general population of State hospitals.

2. Correctional Security Ratings

Traditionally, security in a correctional setting has been based on the security level assigned to an institution in which an inmate was housed. This security designation was usually determined by the security of the perimeter of the institution (that is, a walled institution was considered a maximum security institution; a fenced institution was considered a medium security institution and an institution with minimal or no fencing was considered a minimum security facility). However, each correctional institution may have several different levels of security within its boundaries and thus correctional institutions tend to carry multiple security designations (such as, maximum/medium, or medium/minimum.) More recently the trend has been to assign individual security ratings to each inmate on a case by case basis. This individual rating also tends to carry treatment implications in terms of the amount of security

[11] *MH/MR Act of 1966, Section 202.*

and control a particular individual needs. Because each correctional institution usually has several institutional levels of security within its boundaries and because each institution, regardless of its institutional security rating, usually has inmates with all security ratings in its population, the individual security rating is of more significance than the rating of the institution in which an inmate is housed.

The Commissioner of the Bureau of Correction has published guidelines for security designations in "OM-2, Classification Manual" (September, 1976) and "OM-1, Diagnostic Center Manual" (January, 1977). These individual security ratings are based on the individual's offense, past history, stability and behavior. These classifications are subject to change based on an individual's adjustment in his program and his demonstrated behavior.

The following is a description of the individual security classifications assigned to each individual received in the Bureau of Correction. The four major classifications of individual security and several subcategories (see Table II) are as follows:

a. Persons with a *maximum security* rating are housed in single housing units and are constantly monitored by employees. Most programming for these individuals occurs in the maximum custody unit. All movement within the institution is escorted and transfers between institutions are conducted under physical restraint and close supervision. This custody level is for persons who present a threat of harm to themselves or others or who pose a threat to the security of the institution (for example, escape or riotous behavior).

b. Persons given a *close custody* rating are also placed in constantly monitored, single housing units. Movement within the institution requires constant visual control by an employee and may require an employee escort. Programs and work are available within the institution in areas where constant, direct supervision can be assured. Transfers from the institution are made under physical restraint and close supervision. This custody status is for inmates who require a high degree of supervision but less than maximum custody. Four subcategories[12] further define the reasons for close custody.

c. Persons with a *medium custody* rating are allowed "reasonable freedom of movement and programmings within the unrestricted confines of the institution".[13] Four subcategories under this custody level specify movement or work opportunities as follows:

1) Inside program status allows work or program assignments without direct or constant supervision but within the institution.

2) Limited Outside Status permits work or program participation outside institutional walls but still on the property, and not without direct and constant supervision.

3) Escorted Leave or Privilege Status allows a person to attend special activities or programs, have special privileges (such as outside visiting) or do required institutional work off correctional property but under the direct and constant supervision of correctional staff.

4) Outside Honor Status permits an inmate to work on assignments outside of the institutional enclosure with indirect or intermittent staff supervision.

d. Persons on *pre-release* status are allowed participation in community based programs. Subcategory headings indicate the specific programming privileges allowed: furlough, educational/vocational release, work release, and/or community services center placement.

Table I depicts the Bureau of Correction's individual classification system; Table II shows the security ratings of existing mental health and correctional institutions.

The placement of individuals in specific mental health and correctional facilities is determined by different sources. Commitment to a forensic unit is made by a judge or mental health review officer who considers the security designation of the facility in relation to the individual's behavior, criminal charge or conviction and projected length of stay. Assignment to specific correctional facilities is determined after commitment by the court to one of three diagnostic centers[14] after considering a person's "security needs", based on sentence length, prior record, age, escape and violence history, and "treatment needs". Prisoners transferred to the mental health system on an emergency basis (section 302) are placed in a security status determined after consultation between mental health and correctional officials.

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[12] *Disciplinary custody, administrative custody, limited population, diagnostic center or reception unit.*

[13] *"OM-2, Classification Manual", September 1976, William Robinsion, p. VII-2.*

[14] *Eastern at Graterford, Central at Camp Hill, and Western at Pittsburgh.*

TABLE I

CLASSIFICATION SYSTEMS*
of the
Bureau of Corrections

BUREAU PROGRAM LEVEL	NAME OF STATUS	DESCRIPTION OF POSSIBLE PLACEMENT
I	**Maximum**	Single housing, employee escort needed
I-M	Disciplinary Custody – Maximum	
I-R	Administrative Custody – Maximum	
II	**Close**	Single housing, constant visual control by employee
II-E	Disciplinary Custody – Close	
II-K	Administrative Custody – Close	
II-H	Diagnostic – Assessment	Reception Unit of Diagnostic Center
II-T	Limited Population	Close Custody Cases permitted some general population programming.
III	**Medium**	General freedom for Institutional programming.
III-A	Inside Program	Inmate cannot leave the enclosure
III-B	Limited Outside	Closely supervised outside work assignments
III-C	Supervised Leave	Employee supervised off-the-grounds programs
III-D	Outside Honor	Indirect employee supervision outside enclosure
IV	**Minimum (Pre-Release)**	Inmate allowed off grounds without supervision
IV-F	Furlough	Inmate is permitted furloughs
IV-S	School	Educational/Vocational training release permitted
IV-W	Work Release	Work Release placement
IV-P	Pre-Release	All pre-release programs permitted
IV-G	Community Services	Placement in community center, etc.

**"OM-2 Classification Manual" – Sent 1976*

TABLE II

Security Ratings for Mental Health and Correctional Institutions

FACILITY	DESIGNATED CLASSIFICATION(S)
Mental Health	
Farview	Maximum
Norristown (Psychiatric Forensic Unit)	Medium
Mayview (Psychiatric Forensic Unit)	Medium
Philadelphia (Psychiatric Forensic Unit)	Medium
Warren (Psychiatric Forensic Unit)	Medium
Other State hospitals	Open institutions
Corrections	
Camp Hill	Medium/minimum
Dallas	Maximum (limited)/medium/minimum
Graterford	Maximum/medium/minimum
Huntingdon	Maximum/medium/minimum
Muncy	Minimum
Pittsburgh	Maximum/medium
Rockview	Medium/minimum
Greensburg	Minimum

When sentenced incarcerated prisoners become severely mentally disabled, the treatment "facility is required to maintain custody and control over the person."[15] The transfer of prisoners to the mental health system for mental examination and treatment (Section 401) "shall not affect the conditions of security required by his criminal detention or incarceration", As the security description for institutions within the mental health and correctional systems is not identical, fulfillment of the Section 401 security requirement must be achieved on the basis of equivalent rather than identical security provisions.[16] Here lies the dilemma--what is equivalent rather than excessive or insufficient security?

The Task Force agrees with the Office of Mental Health and Bureau of Correction that security can be provided by various means, such as physical restraints built into the institution (the traditional cell, high wall, and gun tower) and/or in combination with programming, staffing and operational routines. Mental Health is presently more able than Correction to provide staff and environmental forms of security through smaller client populations, higher staff to client ratios, treatment programs and a therapeutic atmosphere. While internal programming and atmosphere may generate distractions from boredom or relieve a sense of purposelessness, ingredients of disruptions and escapes, these security elements cannot be complete substitutes for tight perimeter security. Movement within a maximum security facility must be by escort, and program or work opportunities must be conducted under close surveillance within the areas of the institution deemed maximum security.

As maximum security custody tends to be counterproductive to an effective milieu for mental health therapy, Correction should be encouraged whenever possible to reclassify maximum security cases to a lesser security rating. Also, prisoners who have been held in close or maximum security only on an emergency basis should be transferred to an institution with a security rating commensurate with the person's security needs.

The Task Force recognizes the urgent need for the creation of a common language or set of standards to be used jointly by Correction and Mental Health. As guidelines, these should set forth not only equivalencies or parallel conditions of security, but also establish when and by whom a specific case will be classified and, if necessary, reclassified. As has been pointed out, a confusion exists in terminology and in the purposes to be served; there is also a disparity in the range of security levels or conditions that are available. These uncertainties and deficiencies will have to be rectified in order to promote an effective interchange between the mental health and correctional systems.

C. Mental Health Services for Women

The way the criminal justice system deals with women frequently results in proportionately more female prisoners (detained and sentenced) having mental health needs than their male counterparts. Women are more often diverted from incarceration (their crimes tend to be less serious) yet there are very few community-based forensic mental health services available for them. Also, as a result of small female jail populations, jailed women face a paucity of social services, vocational opportunities, and interpersonal interactions, all which exacerbate latent and clinically recognized mental illness. Thus, the emotional problems of incarcerated women are compounded by lack of care in addition to the isolating conditions of confinement.[17]

Mental health services at the Correctional Institute at Muncy, the only State correctional facility for women, are curtailed because of the prison's primary minimum security status. Presently, because of the lack of sufficient resources, seriously mentally disturbed women are confined in maximum security cells and are held on a short-term basis in the hospital unit. When overflow occurs, they are housed with disciplinary cases in the "behavior adjustment unit". These women are isolated, sometimes for long period of time. Muncy does not have sufficient staff for treatment, nor does it have any medium secure housing. The State hospitals contain no forensic units for women. Furthermore, a regularized system of transferring women between the Correction and Mental Health systems does not now exist. All these inadequacies characterize the severely inappropriately handling of mentally ill female prisoners.

D. System Linkages

The Appendix contains an article describing the treatment and other options which have been available under the Mental Health/Mental Retardation Act of 1966 for mentally ill offenders and defendants.[18] For future planning purposes, Figure 2 and the description which follow present the flow of persons between the Mental

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[15] *Act 143, Section 401.*

[16] *House Bill No. 1486, introduced on July 12, 1977 seeks to amend Section 401(b) in requiring that if an individual detained on criminal charges or incarcerated is made subject to inpatient examination or treatment, he shall be transferred to a mental health facility with security identical to the institution to which incarcerated.*

[17] *From more than twenty-five years of research, it is clear that even the most normal, healthy people demonstrate psychotic reactions to sensory and perceptual deprivation. Isolation and seclusion in county jails can accentuate the illness of people who are mentally ill or marginally ill. (cf American Handbook of Psychiatry, 2nd Edition Vol. 1, p. 1102).*

[18] *See Appendix III for Guy, E. B., Heller, M. S. Polsky, S., "The Disposition of Mentally Ill Offender", Prison Journal, 49, 1: 24-33, 1969 (reproduced with permission of the authors).*

Health and Correctional system under Act 143.[19] As this Report goes to press, it is important to be aware that at least nine amendments have been introduced to Act 143, all of which will be debated in the months ahead. They represent a range of viewpoints.

DESCRIPTION OF FLOW CHART*

1. Mentally Disabled Detentioner

(a) Authority for commitment and transfer to a mental health facility for this individual emanates from Sections 401(a) and 401(b). Commitment is instituted under the provisions of Act 143, and is usually made to one of the Commonwealth's designated forensic units if space is available. If the detentioner remains mentally disabled and is incompetent to proceed, he is retained for the original commitment period, and for additional periods of either 90 or 365 day duration (depending on charges–see 304(7)(g)), if a hearing determines that severe mental disability persists. If competency is restored, however, the detentioner is returned to court. The determination of incompetency effects a stay of the prosecution as long as the incapacity continues, 403(b). A stay, however, shall not be in excess of five years or the maximum of the sentence for the crime(s) charged, whichever is less, 403(f).[20] As to the individual's criminal detention, he is to be detained in jail on the criminal charge no longer than it takes to determine whether a substantial probability exists that capacity will return in the foreseeable future (403(d)). If no probability exists, the individual is to no longer be detained, although the criminal charge remains in existence. If the probability does exist, the criminal detention cannot be in excess of that permitted by Section 403(f) (above).

(b) A court may order treatment not to exceed thirty days for an individual found incompetent, but not suffering from severe mental disability, if the court is reasonably certain that such treatment will restore competency (402(b)). If competency is not regained, then criminal proceedings continue to be stayed, and criminal detention continues unless there is not a substantial probability of the person's regaining competency in the foreseeable future (403(d)). If competency is regained, the detentioner is returned to court.

(c) Procedurally a court may order a competency evaluation (402(d)) upon application of counsel, the accused, the official in charge of the institution where the accused is detained, or sua sponte. Based on the report the court may then order involuntary treatment if the person is deemed incompetent but not severely mentally disabled (402(b)), proceed with the prosecution if he/she is competent, or proceed with the civil commitment process if the person is found incompetent and severely mentally disabled. If competent but severely mentally disabled, prosecution continues despite placement and commitment to a mental health facility.

2. Mentally Disabled Offender

The convicted and incarcerated offender suffering from severe mental disability, upon hearing and commitment, is transferred to a forensic unit on condition that the level of security required by his incarceration not be affected. Commitment and recommitment to such facility continues so long as severe mental disability persists. When said condition is alleviated, the individual is discharged and returned to the authority entitled to have him in custody (401(b)).

3. Not Guilty by Insanity

An individual found not guilty by reason of insanity may be released to the community, or at the discretion of the attorney of the Commonwealth a petition for involuntary commitment under Section 304 may be filed. If he/she is suffering from severe mental disability, commitment to a mental health facility is ordered.[21] The original period of commitment is dependent on the type of crime committed. Murder, voluntary manslaughter, aggravated assault, kidnapping, rape, or involuntary deviate sexual intercourse may result in a one year commitment. Discharge from the facility is mandated if at anytime the director of the facility concludes that the person is not severely mentally disabled and not in need of treatment.[22]

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[19] *Please note some individuals are placed on bail with the condition that they get "voluntary services ".*

* *Numbers and letters correspond to Flow Chart, Figure 2.*

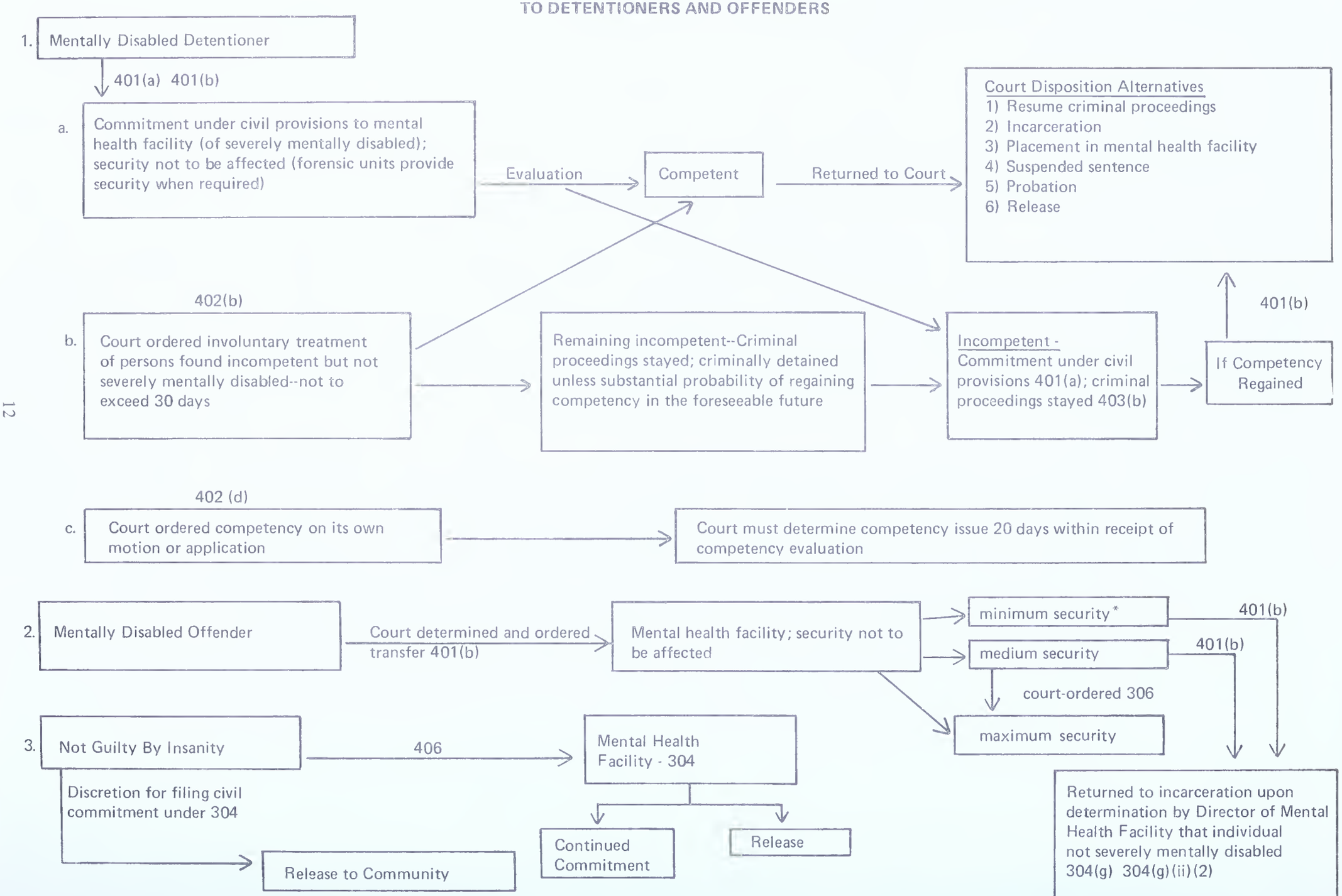
[20] *An amendment to Act 143, Senate Bill 1105, introduced on September 27, 1977 suggests changing the maximum of five years to ten years. This idea is a result of the concern that individuals may be feigning mental illness long enough to avoid prosecution. There is now a premium on being incompetent, whereas previous to Act 143 an incompetent was committed indefinitely or until competency had been restored. This Task Force is divided on this issue.*

[21] *Commitment sometimes occurs to a forensic unit, despite the fact that such individual is a civil patient and technically has no further criminal attachments because of the need for security. Such an individual should be committed to a regular civil hospital and if necessary housed with other civilly committed individuals who require greater security.*

[22] *House Bill 1486 in part seeks to amend Section 304 (g) (2) of the Mental Health Procedures Act of 1976 by requiring, that for individuals committed for one year (i.e., those found not guilty by reason of insanity for certain offenses), and by whom the maximum sentence for the offense has not been served through commitment to a mental health facility, the discharge must be approved by the committing court. The discharge by the committing court would have to be based upon a finding that such an individual would not be dangerous to self or others in the reasonable future. Present Pennsylvania law requires no such approval from the committing court and authorizes discharge when in the opinion of the director of the facility no further mental health treatment is necessary, or when the period of commitment has expired and no petition for recommitment has been granted. Senate Bill 1105 also seeks to amend this section by requiring the director to petition the Court ordering treatment for the unconditional or conditional release of the individual, whenever the facility determines the individual is no longer suffering from severe mental disability. A hearing would follow within 15 days after filing of the petition to determine whether the individual continues to be severely mentally disabled and in need of treatment. The Task Force endorses the concept of reviewing the release decision for individuals found not guilty by reason of insanity, but makes no judgment as to the legalities of such a mechanism. Mr. Reihart of the Task Force supports abolishing the not guilty by reason of insanity defense. Attached as Appendix IV is his suggested legislation to effectuate such abolition.*

Figure 2

MENTAL HEALTH SERVICES
TO DETENTIONERS AND OFFENDERS



*Minimum security is the general milieu of a mental hospital setting primarily of open wards, which may include some closed wards.

Existing Planning

As part of the 1977-78 budget the Department of Public Welfare and the Governor requested a program expansion at a cost of nearly five million dollars for forensic services. It contained the following elements:[23]

(1)	Affiliation contract with medical schools to upgrade clinical services at Farview	$400,000
(2)	Upgrade staffing at existing medium secure units	$702,600
(3)	Provide mental health services in State correctional facilities	$800,000
(4)	Provide program supervision through expanded Division of Forensic Psychiatry and Regional Staff	$ 65,100
(5)	Establish 130 additional medium secure beds	
	Renovation costs	$1,020,000
	Staff costs	485,000
(6)	Provide mental health services in city prisons; this would subsume and modify the existing Holmesburg contract as well as providing limited funds for other city prisons	$1,500,000
	Total Forensic PRR	$4,972,700

None of these items were directly funded in the final appropriation bill although inclusion of forensic services within the 1977-78 Philadelphia County Mental Health/Mental Retardation allocation will probably be possible within existing State resources. The Task Force understands that these were first year figures.

The Future of Farview

The Task Force received and considered many viewpoints regarding the usefulness and viability of Farview. *Among the arguments for continued support are:*

- Treatment at Farview has significantly improved within the last two years.
- The physical plant is in good shape and includes modern facilities for therapy, recreation, and development of vocational skills.
- The cost of recreating physical facilities equal to that of Farview would be too expensive.
- There is a corps of good personnel assembled at Farview who would be unable to relocate to new or other facilities.
- There is a strong spirit of support for the institution among residents of the Wayne County area as well as economic dependency on it.

Positions in support of closing Farview as a maximum security psychiatric facility are:

- The cost of treatment, approximately $63,000 per patient per year is inordinately excessive.
- The remote geographic location has prohibited recruiting fully qualified professionals.
- The remote location makes it impossible for families of patients to have regular contact and for patients to have sufficient access to legal counsel and to the committing courts.
- A continued racial imbalance between staff and patients cannot be rectified because of Farview's location.[24]
- Allegations of abuse of some Farview patients by some staff members is a matter of public record.
- Location and cost deter commitments to the facility.
- The enormous physical size of Farview makes it economically inefficient.

In balancing these pros and cons, the Task Force concludes that Farview should close as a psychiatric facility, when the proposed comprehensive forensic system is in place. Farview's continuation beyond that point in time cannot be justified. A significant element of our proposed plan is the availability of maximum secure mental health services at a regional level. Forensic services are more effective at smaller regional and urban located institutions, as staff at an isolated maximum security unit has the tendency to become institutionalized and hence pessimistic about the resident's prognosis and their own effectiveness in bringing about changes. Furthermore, regionalization combats the tendency of communities, agencies and other institutions to indulge in preventive detention and to incarcerate people at a far distance for their alleged dangerousness. Farview's geographic location in conjunction with present state salary rates prevents attraction of qualified professional personnel. The greater possibility of attracting competent professionals at regional urban units, in addition to more families being more proximate to facilitate visiting, will significantly add to treatment possibilities and success. It will also give patients greater access to legal counsel and the courts.

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[23] *Analysis of these figures is available from the Office of Mental Health.*

[24] *As of January 30, 1976 Farview's population was 38% Black, with 5% Black staff.*

Regionalized forensic programming consisting of multi-level secure units encourages continuous evaluation as to the need for freedom and restriction of the individual patient. It also enhances the patient's ability to adjust to a less restrictive environment as the program and facilities are more visible and hence less threatening. This is not possible at Farview.

III. PUBLIC HEARING FINDINGS

A. Public Testimony

The Task Force held public hearings in Philadelphia, Harrisburg, and Scranton and reviewed written testimony submitted by other interested persons. The key themes running throughout the testimony are:

1. There is a clear and continuing need for maximum security psychiatric facilities, but such facilities should be used on a short-term basis for those mentally ill individuals chronically displaying dangerousness to themselves and others, and for those few individuals requiring long-term maximum security treatment. It was indicated that the optimal size of a maximum security unit is 50-75 beds.

2. As to the location of the secure units, there was consensus that accessibility to the resources of a metropolitan area is important. Testimony documented a need for the development of a coordinated system of regional secure units.

3. The current linkages between the Mental Health and Prison systems was questioned. This included the need for more mental health services in prisons. For those people requiring transfer to mental health treatment, the process must be streamlined. Linkages between Mental Health, Corrections, and the courts need clarification and strengthening. The due process considerations of Act 143 vis-a-vis the mentally ill offender are somewhat contradictory. The aegis of mental health treatment (either in prison or hospital) was debated.

4. Testimony revealed a critical need for forensic services for women and that presently no appropriate facilities exist.

5. The need for mental health services to juvenile offenders was also highlighted. This included services for those juveniles who are not treatable in the present system and those convicted of adult crimes. There was testimony as to the unique treatment needs of juveniles.

6. Testimony relating to Farview State Hospital indicated that:

a) because of its location sufficient professional staff could not be attracted there for employment;

b) family visits were inhibited; and

c) its size and staffing resulted in excessive cost and were not conducive to effective treatment. Others testified that abuses of the past continued in the present.

B. Future Needs for Secure Facilities

One of the purposes of the public hearings was to determine the types and extent of demands on the forensic psychiatric system in the next ten years, as set out in the Governor's Executive Order. As previously indicated, the maximum security care service needs in Pennsylvania are significantly affected by the full range of service provision. Although testimony at the public hearings gave some overview as to what the needs may be, the input is not sufficient on its own. Further, the Task Force did not have adequate data or the time and capability to undertake a reliable effort at population projection.

However, a variety of methods have been employed by states to determine the future size and composition of offender populations, or designated subpopulations such as offenders requiring mental health services. Such projection techniques have included: 1) simple linear (straight line) extrapolation; 2) input/output analysis of influencing factors; 3) multiple regression (multi-variables linear extrapolation); and 4) curve fitting.

The input/output multivariate technique seems to be the best in that it allows some advance warning of the turning point in a population cycle.[25] The ability to predict when rises or declines in a population will occur is essential in the planning and management of institutional capacity requirements, budget forecasting, delivery of the specified services, staffing requirements and other organizational considerations. Below are some of the factors which are frequently used in input/output analyses for correctional population projections (and would also have applicability to the problem of projecting forensic and maximum security populations):

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[25] *Flanagan, John, "Projection of Prison Populations", American Journal of Correction, May-June, 1977, p. 12: "Recent experience suggests that it is more valuable to develop methods that give early warning of major cyclic changes than to develop methods that attempt to improve accuracy of short-term predictions within a given phase of a cycle."*

FACTORS INFLUENCING INPUT/OUTPUT

INPUT

unemployment rate
intake from courts
diversion to community programs
changes in legislation/policy
rate of parole revocation
incarceration rate for "at risk" population (ages 18-29)

OUTPUT

length of sentence
average length of stay for a particular crime
parole and discharge rates

Projections must include historical data, and some estimate of how each of these factors will operate during a future period of time. Unemployment (especially among young females and males between the ages of 16 and 25) seems to be a critical input variable in increases in both prison and mental health hospital admissions (see Appendix V). The Task Force does recognize the need for data gathering and analysis of variables such as those above as part of any future effort to estimate the psychiatric needs of maximum security offenders in Pennsylvania. [26]

Although we know that forty-seven involuntary commitment petitions were filed by the Bureau of Correction from September, 1976, to May, 1977, the reliability and use of this figure for projection purposes is to be questioned. The reasons for this doubt are:

1. As a result of the recent implementation of Act 143, the Bureau of Correction has admittedly taken a conservative approach in filing involuntary commitment petitions. The adjustment to the 1976 Mental Health Act is still in progress. This figure also does not take into account the practices of the county jails.

2. The Bureau of Correction indicates there are many inmates in need of mental health treatment who are unable to meet the criteria for involuntary commitment under Act 143. There is debate as to whether voluntary admissions are allowed under the Act.[27] Some indicate this may be done with court approval, although the Act specifies only involuntary commitment as credit toward time served. Credit should be given as well to time spent as a voluntary patient in a mental hospital. There is considerable hesitancy by judges to approve such transfers based on security considerations and costs. Presently, the county of conviction is required to pay the cost of treatment when a mental health commitment is made from a correctional setting. However, legislation to amend Section 507 of the Mental Health/Mental Retardation Act of 1976 is again pending.

Many inmates in need of treatment are going without mental health services. From a legal perspective it is important to recognize that lack of mental health treatment within correctional settings in conjunction with limited access to the mental health system may, in some instances, be in violation of an individual's Eighth Amendment right to be free from cruel and unusual punishment. See Bowring v. Godwin[28] and Jackson V. Hendricks, supra.

Most of the statistics contained in this section are either derived from testimony or from analysis of population reports. These at best represent estimates of requirements based on past experience and on existing system responsiveness. Efforts should be made by the Office of Mental Health during the next six months to develop the data base procedures and information system capability to establish an ongoing population analysis for appropriate correctional populations in need of acute and/or maximum security psychiatric care and projections of future trends for this population.[29]

SURVEY OF OTHER STATE FORENSIC MENTAL HEALTH SYSTEMS

To fulfill the task of surveying innovative approaches which other states use to meet forensic mental health needs, the Task Force's volunteer staff contacted the departments of Corrections and Mental Health of twelve states, selected on the basis of their reputation as innovators in the forensic psychiatric field. Each department was asked to describe mental health services available to male and female prisoners, requirements and procedures for transfer between the Correctional and Mental Health systems, recent changes in Mental Health's delivery of forensic psychiatric care, provisions for pre-trial competency evaluations, treatment of not-guilty-due-to-insanity cases, and use of or restrictions on involuntary treatment. Only the highlights are summarized here.

To circumvent the traditional inability of departments of correction to attract adequate numbers of professionally qualified, psychiatric staff, Tennessee and Ohio assigned the responsibility of hiring psychiatrists to the Department of Mental Health. Tennessee's department contracts with regional mental health centers to provide services and staff to prisons within their catchment areas.

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[26] *See Brenner, Harvey, Estimating the Social Costs of National Economic Policy: Implications for Mental and Physical Health and Criminal Aggression, Vol. 1 Employment, Paper No. 5, U.S. Congress Joint Committee on Economics, U.S. Government Printing Office, October 26, 1976.*

[27] *S. B. 1105 now seeks to amend Act 143 to allow for voluntary admissions subject to court approval. The Task Force supports this concept.*

[28] *551 F. 2nd 44 (4th Circuit 1977).*

[29] *See also Harvey Brenner's book, Mental Health and the Economy and Richard Light's 1973 Article in the Harvard Education Review.*

Mental health care for female prisoners is scant almost everywhere because there are not enough incarcerated women to justify fiscally a full service component. Thus, proportionately more women than men are transferred to state hospitals or inappropriately held in prison segregation units.

Courts and legislatures are stipulating stricter criteria for transfers from prison to a State hospital. Ohio, with the strictest criteria of the surveyed states, requires a person to have recently committed an overt, harmful act and be judged mentally ill. To care for prisoners not meeting the threshold for transfer and to design a mental health program appropriate for prisoners (usually described as occurring in a setting structured for behavioral change rather than a medical setting oriented toward facilitating swift return to the community), four states have developed or are developing secure medical facilities under the domain of their respective Departments of Corrections. The most adequately staffed one (Iowa) is located near, and draws from, a university hospital. Two other states are developing, for acutely ill prisoners, forensic units in State hospitals, either throughout the State or near major population areas. These states contend that, as much as possible, forensic mental health services should be provided by regular state mental health staff.

Two states are leading the field in providing courts with swift, inexpensive, sound pre-trial competency evaluations through the use of court evaluation teams or "court clinics". These teams complete pre-trial evaluations on an outpatient or in-jail basis. In Tennessee, Master's level mental health professionals who have attended a specific course are qualified to do the evaluations. Tennessee claims it completes eighty percent of its evaluations on an outpatient basis; Massachusetts claims its court clinics have significantly reduced the use of hospitalization for evaluations and subsequent dispositions.

The prevailing procedure for cases involving pleas of not guilty due to insanity included (a) a court finding of the charge (N.G.I.); (b) when requested, a sixty to ninety days' hospitalization for evaluation; a commitment hearing, and subsequent civil commitment or release.

Four states interpret a court order for hospitalization to mean a responsibility to administer treatment regardless of consent. Among these, California has adopted the most detailed set of regulations varying with the type of forced treatment; only tranquilizers can be involuntarily administered without a court order and then for only ten days.

Of all states surveyed, Tennessee, with its decentralized hospital forensic units and prison services provided by regional mental health centers, is most often described as the most forward looking state in the field of forensic psychiatry.

THE DEVELOPMENT OF A FORENSIC SYSTEM

A. Design of the System

The Task Force has considered various ways of providing forensic mental health care,[30] and recommends developing a comprehensive forensic psychiatric system. This system must include: 1) the provision of mental health services within the State prisons (in essence outpatient and diagnostic services); 2) multi-level secure inpatient forensic units at selected State hospitals; 3) crisis intervention, preventive and aftercare services within the county jails; and 4) county court diagnostic clinics.

Such an extensive system would be able to address the needs of prisoners who presently are not committable to an inpatient mental health facility. Currently, there is a paucity of prison mental health services (see Appendix VI) resulting in the transfer of individuals to the mental health system. The availability of diversified services would also serve to limit the numbers of persons needing maximum security psychiatric treatment.[31] A fuller description of the components of this forensic psychiatric system follows.

1. Services in Correctional Institutions [32]

In accordance with the philosophy and stipulations of the 1966 Mental Health/Mental Retardation Act, a prison shall be considered as part of the general "community" with a concomitant need for mental health services. Thus, prisoners should be afforded, within the correctional setting, all the mandated services which are available to the non-prison mentally ill population in Pennsylvania. These services would include emergency and crisis intervention, diagnosis and evaluation, and consultation and education. However, the inpatient mental health treatment should be provided to prisoners in the mental health hospital system, rather than in prisons.

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[30] *The Task Force reviewed the following approaches among others:*

(1) The mental health system supplying treatment at mental health facilities (presently Pennsylvania's system).
(2) Development of a joint mental health-correctional facility to provide treatment for those incompetent to stand trial and prisoners with specialized needs.
(3) The Bureau of Correction developing the capacity to provide mental health treatment for its population in its prisons.
(4) Expansion of the community mental health system to serve persons in county jails and persons leaving State prisons.
(5) Development of mental health services in State correctional institutions and expansion of county court diagnostic units.

[31] *The phrase "maximum security psychiatric confinement" is used since under the law, security considerations take precedence over treatment issues. Corrections' responsibility for preventing escapes gives rise to a setting which severely limits mental health's ability to establish an effective treatment milieu. Thus the use of such facilities should be limited to short-term treatment or for those few mentally ill individuals who have demonstrated repeated assaultive behavior.*

[32] *See Appendix VII "Manual of Standards for Adult Correctional Institutions", particularly sections 4275 and 4279.*

The Bureau of Correction will need to establish the distinct services cited above for the care of mentally ill offenders. The extent of these services will depend on the number of inmates in need.

The Office of Mental Health should develop professional guidelines, policies, and standards for the provision of these services. Funds for these services should be budgeted through the Office of Mental Health. Also, this Office should continually monitor the flow of individuals between mental health and correctional systems.

The Bureau of Correction and the Office of Mental Health should share the responsibility of recruiting and selecting mental health staff qualified to render services in prison.

Mental health professionals working within correctional facilities will, of necessity, be faced with a dual role. They will need to be responsible to the administrative and security demands of prisons and hence administratively responsible to the superintendent. At the same time, these professionals will need to be responsible for following the treatment policies and professional standards established by the Office of Mental Health. Thus, representatives of the Bureau of Correction and the Office of Mental Health must meet regularly to insure that priorities, policies, and guidelines of both departments are coordinated and observed. This coordination should begin with the implementation of this report. (A method for accomplishing this and particular topics to be addressed are set forth on pages 20 and 21 under the "Implementation" section of this report.)

Recruitment of the best possible staff is an issue of concern to the Task Force. Salaries must be increased to reflect the difficult work setting and potential hazards. Also, medical and graduate schools should be encouraged to develop appropriate training in order to interest professionals in forensic mental health care early in their professional careers. It is erroneous to conclude that board certified psychiatrists and people trained in related disciplines must receive, and will be willing to receive, additional post-graduate training to work in a forensic setting. Instead, medical school residency programs and university graduate programs should institute, within their regular programs, specific training to increase and enrich the reservoir of professional personnel interested in forensic mental health work. Appropriate funding should be legislated to support the development and effecting of these training programs. Once appropriate funding is in place for this training, other state funding should be conditioned upon the implementation of these training programs. The Task Force recommends that this development be a condition of their funding from the State. Appropriate funding should be provided commensurate with these mandated services.

The provision of mental health services in prisons raises two issues:

a. when transfer to the mental health system is appropriate; and

b. what constitutes legally acceptable involuntary treatment. With regard to these issues, the Task Force recommends all possible treatment short of inpatient care, should take place in prison with expeditious transfer only when clinical judgment indicates. The Task Force anticipates that mental health interventions will take place in the following sequence.

An inmate within the general population begins to exhibit behavior of concern to other inmates or staff. If mental illness is suspected, the inmate's behavior is monitored and frequently he/she is referred to medical services. Where violent, aggressive or bizarre behavior is displayed, the inmate is usually transferred to a more secure environment within the institution. At this point, medical and mental health personnel become more directly involved in the evaluation of the person's behavior and provision of intensive or emergency treatment.[33] If at any stage in this process, it is determined that the situation is acute (either because the inmate presently being monitored in the hospital or general population progressively deteriorates or because an inmate suddenly becomes identified by the commission of some serious act against another person or him/herself), a transfer to a forensic unit at a State hospital would be effected by the prison.[34] (Note that Section 302 of Act 143, "Involuntary Emergency Examination and Treatment

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[33] *The Task Force considered the legal aspects of providing treatment in prison with or without the inmate's consent.*

As to treatment for physical illness, it is clear that informed consent is necessary except in cases of extreme emergency, where consent is implied. See for example, Gray vs. Grunnagle 423 Pa. 144,223 A 2d 663 (1966). Many of the same considerations would appear to apply to treatment of the mentally ill. The scope of Act 143, however, purports to cover "all involuntary treatment of mentally ill persons whether inpatient or outpatient and. . . all voluntary inpatient treatment. . . . ." Section 103. There is also a provision that when someone in prison". . .is made subject to inpatient treatment, he shall be transferred to a mental health facility"; and "inpatient treatment" is defined as that which requires "full or part-time residence." Section 103 and 401(b). The Task Force concluded that most instances of treatment in prison fall into the category of outpatient and that the procedural requirements of Act 143 must be met whenever such treatment is not voluntary or rendered under highly exigent circumstances.

Where inpatient treatment becomes necessary, Act 143 provides that an inpatient facility must satisfy hospital accreditation standards unless exempted annually by the Department of Public Welfare. Section 105. However, as it relates to those in prison, the distinction between inpatient and outpatient treatment appeared to the Task Force to be unrealistic and often unhelpful. According to Task Force members and other mental health professionals experienced in prison work, many inmates treated in a prison setting do well even though they might be thought of as "residential" or inpatient cases. The better rule or classification would seem to depend on whether the inmate, following crisis intervention or other initial treatment, continues to make progress toward recovery. The period of treatment involved could last several weeks. The Task Force therefore urges the Department of Public Welfare to take steps to grant appropriate exemption for this purpose or, in the alternatives, would support legislation clearly authorizing short-term inpatient treatment, voluntary and involuntary, to take place in prison.

[34] *The Bureau of Correction visualizes a number of possible examples of persons requiring transfer for treatment. See Appendix III.*

Authorized by a Physician--Not to Exceed 72 Hours" indicates that involuntary treatment at a treatment facility can be administered when a physician upon examination determines severe mental disability and need of emergency treatment for 72 hours.)[35]

In some cases, immediate emergency psychiatric treatment can be of very short duration and the inmate can be returned to his correctional institution to follow-up outpatient care. However, if the mental health hospital staff feels that the inmate requires additional inpatient treatment, an extension hearing must be initiated. Evaluation of the status and treatment needs of the inmate would be ongoing as stipulated under Act 143. In the greater number of instances, it is anticipated that the offender will be returned to his/her correctional institution, terminating the inpatient status. It is anticipated that as the provision of psychiatric services within the prison progresses, many of these returned offenders will receive short-term follow-up, outpatient psychiatric services within their respective correctional institution.

2. **Forensic Units in State Hospitals**

The presently existing forensic units at Norristown, Mayview, Philadelphia and Warren should continue to be developed. The Task Force recommends that a similar unit be developed in the Central Region of the State. Use of these units should be limited to (a) prisoners who become acutely mentally ill while incarcerated; (b) mentally ill, detained incompetents who are likely to regain competency; and (c) county prisoners who require treatment beyond that supplied in the jails through the development of liaisons with County MH/MR units. The forensic units should also be available for individuals pleading not guilty by reason of insanity while they await trial. The Task Force recommends that forensic units not be used for civil involuntary patients who may need a more secure setting.

The design should include several levels of security in one facility. Three of the potential five units need to have maximum security capability. The establishment of multi-level security forensic settings will resolve the problems and costs of establishing one or two units solely as maximum security facilities. The development of these units will also allow confined individuals to be closer to families and legal counsel, as well as providing greater access to the accompanying full staff complement.

Security needs and due process rights of the patients are integral elements in transfers from the correctional system to these units. Section 401(a) stipulates that the sentencing judge must authorize that the transfer of a prisoner to a mental health unit shall not affect the conditions of security required by his criminal detention or incarceration.

Under the present structure, the cost of commitment to mental health facilities is billed to the county where such individual was tried, even though the individual may be committed from a State correctional institution located in another county. The Task Force agrees that counties should not have to incur this cost, but that it should be borne by the Commonwealth.[36] Under this suggested structure, corrections personnel should be less hesitant to petition for involuntary commitment and judges more willing to order involuntary commitment since their counties would not be fiscally encumbered with the cost.

3. **Mental Health Services at County Jails**

Historically, the county jail has become the repository of individuals in need of mental health treatment. This appears to be particularly so under the new provisions of Act 143 and its current interpretations. However, essentially little or no mental health services are available in these jails.[37]

The Task Force recommends that the county MH/MR units provide mental health services in jails located within their catchment areas. The method of providing such service should be by contract with community mental health centers or direct staff. Involuntary treatment provisos need to be considered and standards defined as to the extent of services. The provision of mental health services in jails falls under the duties of the Department of Public Welfare as stated in the 1966 Mental Health/Mental Retardation Act, Section 201: "to assure within the State the availability and equitable provision of mental health...services for all persons who need them regardless of...residence...or social status."

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[35] *With the expansion of a central office for forensic development and coordination, and the delivery of mental health services by mental health personnel, the mechanism for effective monitoring and administration is supplied to protect against potential abuses. Furthermore, personnel should attempt to notify the inmate's attorney and/or nearest of kin in addition to the central forensic office of all involuntary emergency treatment. Records must be kept of all medications.*

[36] *S.B. 599 seeks to accomplish this. The Task Force supports such legislation not including the retroactivity on this bill.*

[37] *A recent survey of county correctional facilities indicated that the number of commitments to mental health facilities from county correctional institutions under Act 143 (845 commitments versus 471 commitments). Belford, R. "Survey of Mental Health Resources in County Correctional Facilities", October, 1977, pp. 4.*

The Task Force underscores the concept of the Mental Health/Mental Retardation Act of 1966 that services be on a 90% State 10% county basis, unless specifically identified in that Act as being 100% State.[38] The counties should have funds available for this purpose if S.B. 599 is passed as the Task Force recommends and counties no longer have fiscal responsibility for prisoners in State mental hospitals. As the Department must approve the annual county plan for the county to receive the annual grant for services (Section 509 of the 1966 Mental Health/Mental Retardation Act) the Department can potentially reject any plan not calling for the provision of mental health services to the jail population. If after approval of a county plan, including forensic services, the Department determines that a county or combination of participating counties is not complying with required services, the Department shall provide such services. Under Section 512(d) when the Department shall provide the services, the county must pay its share computed in accordance with Section 509 (90%) plus an additional fifteen percent of the net cost to the Commonwealth for the county program. Section 509(5) indicates, however, that the counties are required to provide only those services for which sufficient funds are available. Therefore, it is necessary in order to insure adequate delivery of forensic services, that sufficient monies be appropriated.

Steps must be taken to develop a mechanism whereby the counties will have the monetary resources and personnel to provide these much needed services. The Task Force acknowledges that counties continually struggle to provide needed services within the restraints of limited financial resources available. More resources simply must be made available.

4. Local Court Diagnostic System

Court diagnostic clinics are usually established for the following purposes:

a. To eliminate unnecessary commitment of adults to State hospitals for observation;

b. To examine and evaluate persons immediately rather than unnecessarily committing them to county jails and State prisons;

c. To be immediately available to the court for consultation on problems involving legal-psychiatric issues; and

d. To support and enhance the investigative and rehabilitation functions of probation with consultation and inservice training.

Court clinics should become involved in cases as a result of referrals made only by a judge or his designee. Referrals should be conditioned upon the court's need to have information of a clinical nature about a defendant's competency, sanity, criminal responsibility, commitment, dangerousness, probation risk and pre-sentence and treatment needs. Cases should be seen on demand, examinations done, and reports returned in accordance with the court's trial schedule.

In the past, two main approaches have been used in developing local court diagnostic clinics. One approach, such as exists in Philadelphia, uses the clinic only for diagnostic and pre-sentence consultation purposes, the clinic being located within City Hall where many of the courts are also located. Treatment in Philadelphia occurs within the Holmesburg Prison. No outpatient services are available to individuals within prison settings through the court system. A second approach, such as exists in Bucks County, uses the clinic for diagnostic, pre-sentence diagnostic consultation, and treatment purposes. Diagnosis and treatment functions are provided through the prison with outpatient services being available to those individuals coming through the court system.

Although the Task Force recommends that diagnosis and treatment services be available in the county jail system, these need not be established as distinct and apart from one another. Either of the above approaches is satisfactory as long as both diagnosis and treatment are provided. If, however, a county (or group of counties) decides to provide diagnosis and treatment jointly, then there should not be a separate component for treatment within the county jails established through the county MH/MR system. Counties must be given the flexibility to opt for the method of providing diagnosis and treatment which best suits their needs.

The Task Force recommends that funding for these clinics be through the county MH/MR system on a 90% State/10% county basis. Where counties are already operating such units their level of fiscal participation should be continued. The design and operation of the clinics will be a county responsibility and will be subject to annual review by the Department of Public Welfare.

Establishing Forensic Services for Women

The Task Force agrees that forensic mental health treatment for women should follow the same pattern as that for men, and include emergency and non-acute treatment available through mental health personnel in jails and prison, decentralized, multi-level secure forensic units in State hospitals for women offenders.

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[38] *Those services which the State funds at a 100% level are inpatient, partial hospitalization and interim care services (this latter for the mentally retarded).*

The following recommendations are made for establishing adequate services for women:

1. A total of forty beds should be created within the State mental hospital forensic units to serve women who do not respond to treatment provided in jail or prison, need inpatient psychiatric care and meet the criteria of the Mental Health Procedures Act of 1976. Women in the Western Region would be best served by a fifteen bed unit near Pittsburgh. Women in the Eastern and Northeastern part of the State should receive care in a fifteen bed unit being established at Norristown. Women in the Central Region of the State could be served by a ten bed unit established at a hospital in that Region, to be designated as maximum security. This unit could then serve the needs of Muncy and would be equally accessible to both the Western and Eastern areas of the State. The final location of this unit would have to be determined on the basis of resources and need.

Only one unit need have maximum security capability as the great majority of women do not exhibit the type of assaultive behavior requiring maximum security. Intensive staffing in a medium security unit can be an adequate alternative in most situations.

2. A full component of mental health staff and services should be available at Muncy. Staff should be attuned to the particular mental and physical health service needs of women. The staff should include male and female professionals, paraprofessionals, and peer counselors.

3. With the cooperation of county MH/MR units, development of mental health services and staff in the county jails should begin. These services should be identical to those offered to men, except that staff should be sensitive to the particular needs and perspectives of women.

A staff position within the new forensic staff of the Office of Mental Health should be designated as responsible for developing and monitoring forensic mental health services for women. The same functions which are assigned to the forensic unit for men would also be carried out for women.

Finally, the provision of forensic units for women within the State hospitals should be given a top priority due to the present complete lack of services. Staffing of the unit being developed at Norristown State Hospital could be an immediate beginning.

B. Implementation

Successful implementation of the Task Force's recommendations depends on the coordinated efforts of county government, the State legislature, the Office of Mental Health, the Bureau of Correction, and the sub-divisions of these organizations. The State legislature and county governments must authorize finances and pay for the recommended mental health services, staffing and facilities. The State legislature must also pass the enabling legislation described in this report (See page 21). The Office of Mental Health and Bureau of Correction share the administrative responsibilities of implementation.

The Task Force would anticipate that the Commissioner of Mental Health, Commissioner of Correction , Superintendents of Philadelphia and Pittsburgh County jails, head of the Office of Mental Health, Department of Forensic Psychiatry, a designee of the Attorney General, and appropriate staff members will meet on a monthly basis to plan for, develop and review the requisite forensic mental health services.

Critical tasks to be accomplished in these intra-departmental meetings include the need to:

1. Develop a dual information and reporting system (See Recommendation 4) so that service needs can be readily projected.

2. Establish shared or equivalent definitions of individual and institutional security ratings and establish when and by whom specific cases are to be classified.

3. Plan for, design and oversee the establishment of forensic units in appropriate State hospitals.

4. Assure the provision of mental health services in the prisons and county jails.

5. Assist interested counties in starting court diagnostic units.

6. Oversee the establishment of accounting and billing procedures.

7. Review the ongoing operations of forensic mental health services; in particular, intra-system transfers, staffing, recognition of procedural safeguards, costs, and new intra-system problems and data collection.

8. Develop a timetable for the implementation of the recommendations of this report.

To insure that this implementation process continues in the spirit of the Task Force's recommendations, the Governor should appoint a monitoring body consisting of a limited number of active and informed citizens and professionals involved in corrections and mental health fields. This body would see that the Bureau of Correction , Office of Mental Health, State legislature, county governments, correctional institutions and State mental hospitals fulfill their responsibilities as outlined in this report. The monitoring body should regularly make their findings publicly available.

C. Organizational Framework

In order for the Commonwealth to develop a comprehensive forensic mental health system, the Office of Mental Health needs to expand its staffing for forensic services directly attached to the Deputy Secretary for Mental Health. Duties of the central office as recommended by the Task Force have been previously defined.

The Office of Mental Health should develop a clear and effective organizational framework for establishing and monitoring forensic services.

D. Legislative Recommendations [39]

The Task Force concludes that its recommended plan for comprehensive forensic services can only be implemented with a clear legislative base.[40] This will require several steps:

1. Amending the 1966 Mental Health/Mental Retardation Act so that it specifically defines community to include persons in prisons and jails who are thus entitled to mental health services.

2. Amending Act 143 so that individuals incompetent to stand trial or found not guilty by reason of insanity, and thereafter involuntarily committed to a State hospital, are not released to the community without prior court action. Presently these persons are released when the director of the treatment facility determines that they are not longer severely disabled or in need of inpatient services.

3. Amending Act 143 to clearly permit emergency involuntary treatment in a prison setting without involuntary commitment even though the prison will not necessarily be designed as a treatment facility. Safeguards of Act 143 should apply.[41]

4. Passage of legislation to allow voluntary commitments from correctional settings to mental health settings.

5. Passage of legislation that provides for the Commonwealth to bear the cost of treatment for convicted individuals transferred from correctional settings to mental health settings (presently charged to the county of conviction).

6. Legislation providing sufficient appropriations to clearly demonstrate the commitment of the General Assembly to the recommendations of this Task Force.

7. The General Assembly must provide enabling legislation to establish new multi-level security forensic units.

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[39] *Appendix IX sets forth the position of the Attorney General in regard to these legislative recommendations.*

[40] *Several of these recommendations have already been introduced as legislation.*

[41] *The Bureau of Correction takes the position that the safeguards of Act 143 are designed for use in the free community and the environment of the correctional institutions is vastly different from the free community. Therefore, certain modifications in Act 143 may be necessary to facilitate treatment in a correctional institution (e.g., should the 302 requirement of an examination within two hours be modified in light of the fact that correctional institutions do not have doctors on duty 24 hours a day and in light of the fact that the inmate is not being restrained in a sense that a prison in the community would be restrained; is notification of family necessary in that there has been no change in the inmate's residence, etc.).*

E. Estimated Costs for Developing Comprehensive Forensic Services

The Task Force has not overlooked the cost factor of its recommendations but is certain that a Commonwealth investment in this area will have long range benefits for all citizens. As a point of departure a preliminary estimate of the cost of the major elements of this proposal was developed. Additional refinement will be needed. These figures were provided by the OMH.

Cost Estimate: Task Force Proposal: Institutional Construction

1. **Construction — Maximum Security**

a)	50 bed Western unit (1200[42] x $90[43] x 50[44]) =	$ 5,400,000
b)	75 bed Eastern unit (1200 x $90 x 75) =	8,100,000
c)	25 bed Central unit (1200 x $90 x 25) =	2,700,000
d)	10 bed Women's unit (1200 x $90 x 10) =	1,080,000

2. **Construction — Medium Security**

a)	25 bed Central unit (1200 x $90 x 25) =	$ 2,700,000
b)	25 bed Eastern unit (Renovation) =	320,000
c)	30 bed women's unit (1200 x $90 x 30) =	$ 3,240,000
	TOTAL CAPITAL COST	**$23,540,000[45]**

Cost Estimate: Task Force Proposal: Non-institutional

1. **Services to State prisons**

8000 prisoners x 15% = 1200 clients
$25/session x 52 sessions x 1200 = $1,560,000
100% funding new appropriation — $ 1,560,000

2. **Services to county jails**

Philadelphia	$1,000,000
Allegheny	750,000
39 Other Units	1,950,000
	3,700,000
	x .90 (percentage of State Funding)
	$3,330,000

3. **Services to county courts**

Philadelphia	$ 250,000
Allegheny	200,000
Bucks	100,000
38 Other Units	1,520,000
	2,070,000
	x .90 (percentage of State Funding)
	$1,863,000

TOTAL ANNUAL COST — $6,753,000

42: Represents the total space required per patient. This includes patient living space, recreation areas, program space as well as necessary office facilities for staff. Thus, the figure represents the space required for a fully self-contained unit providing for the security & program needs of the patient.

43: Represents the construction costs per square foot

44: Represents number of beds

45: New construction design should provide for limited expansion of these facilities if necessary

Cost Estimate: Task Force Proposal: General Government

1. **Central Office**

2 Psychologist II	$44,400	
1 System Analyst III	19,400	
1 Clerk Steno II	10,300	
½ Programmer II	8,500	
Salaries	82,600	
Benefits	24,800	
Computer time	5,000	
		$ 112,400

2. **Regional Offices**

4 Social Workers III	$74,400	
Salaries	74,400	
Benefits	22,300	
		$ 96,700
	TOTAL ANNUAL COST	**$ 209,100**

Cost Estimate: Task Force Proposal: Annual Operating Costs of maximum security units at State Hospitals

1.	Program staff additional medium security units (staffing ratio of 1.5: 1 = 120 staff @ $17,000)		$2,040,000
2.	Program Staff new maximum security units (staffing ratio at 2:1 = 320 staff @ $17,000)		5,440,000
3.	Incremental operating cost new bed (240 beds x $20.61 x 365)		1,805,000
4.	Total new cost 81-82 fiscal year		9,285,000
	a) less: Farview operating cost	$14,900,000	
	Net: (represents difference between operating Farview & operating new multi-level secure Forensic units)	5,615,000	

Cost Estimate: Task Force Proposal: Relieve County Liability

1.	Relieve county of liability for commitment cost	$10,000,000

Note: Until such time as the new multi-level secure forensic units are established certain additional costs will necessarily be incurred at Farview.

These are

1.	Life Safety Code Renovation at Farview	$ 600,000
2.	Upgrade treatment staff at Farview (8 professional positions)	296,000
		$ 896,000

VI. RECOMMENDATIONS

1. Establish a Comprehensive Forensic Mental Health System

Essential elements of the Task Force proposal are: multi-level secure forensic units, mental health services at State correctional institutions, mental health services at county jails through the County MH/MR System, county court diagnostic clinics and a strong forensic unit within the Office of Mental Health. To assure action upon this proposal the Office of Mental Health should develop a detailed implementation plan within six months after the Governor approves this report.

2. The Future of Farview

The Task Force acknowledges that Pennsylvania must provide maximally secure forensic psychiatric care for the protection of all people and treatment of acutely ill, dangerous offenders. Farview as it exists, however, has no place in an efficient and effective forensic mental health system. Costs in excess of $63,000 per patient per year are prohibitive.

The Task Force consensus is that Farview must be closed by the end of 1980; to close Farview by the recommended date will require that the proposed comprehensive forensic system be fully operative. This is necessary to assure that security and treatment facilities are continuously available.

3. Mental Health and Corrections Should Establish Interagency Committees to Plan and Implement a Forensic Psychiatric Maximum Security System

The provision of mental health services to detentioners and offenders requires extensive coordination and cooperation between the Bureau of Correction and the Office of Mental Health. In order to address the design and implementation issues inherent in establishing a forensic mental health system, the Office of Mental Health and Bureau of Correction share administrative responsibilities for implementation. In addition, it is recommended that the Governor appoint a monitoring committee to oversee the movement towards implementation of this report. See pages 20-21.

4. Establish a Forensic Information System

The Office of Mental Health, in cooperation with the Bureau of Correction , should establish an information system that is able to:

Aid in identifying the types and categories of psychiatric treatment required by offenders and related services needed by correctional agencies.

Collect specific data that will be useful in projecting numbers of offenders who require maximum security psychiatric care.

Provide rates, flows and costs to decision-makers for future planning of facility space requirement, personnel and service needs, and budget requests.

Monitor patients transferred from State prisons and provide information on length of stay, services required, and case management/review for special commitment categories.

5. Creation of a Central Staff for Forensic Services Within the Office of Mental Health

This staff would be responsible for: developing policy, initiating the design and improvement of forensic units, working with County Mental Health/Mental Retardation System to develop services for county jails, monitoring and expediting the flow of individuals within the system, and participating in the development of a county court diagnostic system.

6. Establish Comprehensive Forensic Services for Women

To serve the mental health needs of women offenders, the Commonwealth should develop forensic services for women. These include, mental health services at Muncy Prison, mental health services in county jails, and a specific staff position at the Office of Mental Health Central Office to be primarily responsible for forensic services to women. Distinct forensic women's units in three of the State hospitals must be established. This is a top priority.

7. Address the Psychiatric Needs of Juvenile Offenders

Further study is needed to determine the forensic needs of persons in the juvenile justice system. It is recommended that a Task Force be established to investigate the problem and propose a solution.

8. Set Up a Voluntary Mental Health Commitment Procedure for State Prisoners

A mechanism for voluntary commitment of mentally ill offenders to mental health settings with appropriate safeguards, subject to court approval, be established. Credit should be given to time spent as a voluntary patient in a mental hospital.

9. Implementation of Act 143 in Correctional Institutions

It is recommended that the safeguards of Act 143 be appropriately applied within correctional facilities.

10. Funding of Forensic Mental Health Services

The Commonwealth should incur the expenses of providing mental health services for persons in prison who are transferred to mental health facilities, increase the level of funding to counties for the purpose of forensic services in

county jails, increase salaries to attract qualified personnel at State hospitals and to grant appropriate state funding to mandate the involvement of medical and graduate schools in forensic services.

11. Aiding Wayne County Area

To offset any adverse effect on the economy of the Wayne County area caused by the closing of Farview, the Governor should exert every effort to help Wayne County develop a sound economic base. Strong consideration should be given to exploring what, if any, alternative uses could be made of Farview.

12. Involvement of the Public in the Implementation and Monitoring Processes

The recommendations of the Task Force will only be achieved if there is full community understanding, participation and acceptance in the planning and implementation stages. A careful public strategy must be planned to include legislators, hospital superintendents and Boards of Trustees, judges, district attorneys and mental health groups.

Groups of interested citizens should be encouraged to form monitoring bodies for mental health and prison forensic psychiatric units within their geographic areas.

Finally, the Task Force recommends that a limited number of active citizens and professionals be appointed by the Governor to monitor the continued progress of the Bureau of Corrections and the Office of Mental Health in the implementation of this Task Force's recommendations.

ADDITIONAL COMMENTS

Dr. Daly dissents in part:

Until an alternative forensic system which replaces the services of Farview is developed, the establishment of an arbitrary closing date is unrealistic.

I also agree with Dr. Biele's comments.

Mr. Boyer dissents in part:

I non-concur with the consensus that Farview must be closed by 1980. The psychological effect of such a recommendation now, upon both the employes there and the citizens in the community (since it is almost totally dependent upon said employment) would understandably be devastating. The decision to close Farview should only be considered after the proposed comprehensive, forensic system in the Commonwealth is in actual operation.

Consideration should be given, as early as possible, to review the practicability of utilizing as much of the Farview properties, as deemed possible, for other purposes; so as to lessen the economic impact upon the workers and the community if and when Farview's present operations may be finally closed.

To prevent said community from possibly becoming a "Ghost Town" this should be done.

Mr. Reihart dissents in part:

Farview presently is an essential part of the forensic mental health system in Pennsylvania. It must not be closed until other facilities are available which can provide for the care and protection of those persons who need maximum security psychiatric care. I agree with Dr. Daly that an arbitrary closing date is unrealistic. I would also add that closing Farview without the alternative forensic system in place and functioning would constitute an irresponsible, inhumane, and dangerous act of government.

Senator O'Pake dissents in part:

In addition to agreeing with the dissents of Representative Scirica, Dr. Daly and Mr. Boyer, as a member of the Pennsylvania Senate I feel constrained to add an additional caution. In these times of fiscal difficulti ., every expenditure of the public's tax dollars must be judiciously guarded. There is too strong a tendency at present to scrap existing programs and facilities that are fully functional. Decisions to so change present systems cannot be based solely on idealistic and emotional resolutions of the problem. I do not feel comfortable with either the costs projected by the Task Force, or the manner in which they were determined.

It is critical, in order to evaluate a proposal for any major program change, to have a responsible, detailed fiscal analysis. Without such research and planning, it is simply not possible to adequately compare existing with projected costs, much less recommend abolishing existing programs. As a member of the Legislature which will eventually be called upon to fund whatever new direction is taken, I have practical problems with a plan so unrelated to fiscal reality.

Representative Scirica dissents in part:

I do not concur with Legislative Recommendation No. 7.

The General Assembly will oversee the development of the forensic mental health system through its control of the appropriation of public money.

Multi-level security forensic units will be created only if the Legislature agrees to fund them. It is not necessary to pass enabling legislation for the specific purpose of establishing these units.

Dr. Biele comments:

I submit the following comment which should not be construed as changing the intent, tone or conclusions of the Task Force.

The staffing of the maximum security unit (as in Section 2(a) under the section entitled, "Security Definitions") should consist of two separate disciplines both of which will function at a high level of mutual collaboration. The matter of physical security should be handled exclusively by correctional officers from the Bureau of Corrections. All psychiatric matters will be administered exclusively by mental health personnel assigned by the Office of Mental Health. Thus, those personnel engaging in the therapeutic process will not be identified with those who are responsible for issues relating to punishment and safety. Nevertheless, physical security will always take precedence over any other issue among those who have been deemed to require maximum security. On the other hand, matters relative to psychiatric evaluation, treatment and change of status predicated either on psychiatric improvement or intensified psychiatric disability should be the exclusive responsibility of those professionals functioning under the aegis of the Office of Mental Health.

SEPARATE REPORT OF JUDGE EDMUND V. LUDWIG ON THE NEED FOR MAXIMUM SECURITY PSYCHIATRIC FACILITIES IN PENNSYLVANIA

I agree, in substance, with the findings and recommendations of the majority of the Task Force, and I have joined in its Report. One vital aspect of the Report, however, in regard to the future of Farview State Hospital, requires specific comment and a markedly different emphasis.

The Task Force was unanimous in concluding that there are extremely dangerous mentally ill offenders who must be kept, involuntarily, in maximum security facilities. Historically, the sole institution ever to be designated for such persons in Pennsylvania is Farview State Hospital, which was opened in 1912 as a hospital for the criminally insane. As reflected in the Task Force Report, despite many recent improvements, it is arguable whether Farview should be continued as a maximum security mental health facility, particularly in view of the escalating considerations that now approach 65,000 per resident per year. The Task Force Report recommends, after much consideration, that Farview be closed by 1980 and that alternative maximum security units be established and made available for use in the meantime.

This recommendation, as worded, is not acceptable to the Pennsylvania Conference of State Trial Judges, the membership of which includes nearly every Common Pleas Court Judge and Municipal Court Judge in the Commonwealth. The reason, in large part, is that it puts the institutional cart before the executive or legislative horse. At this moment, the Commonwealth cannot afford, whether by executive order or act of assembly, to take the risk of deciding on any specific closing date for Farview State Hospital. Instead, an appropriate timetable should call for the immediate development of alternative institutions. Once these have been built, opened, staffed, and found to be serviceable, then, if the circumstances so dictated, maximum security commitments to Farview could be discontinued.

In January of this year, exactly the same question was presented to the Pennsylvania Conference of State Trial Judges by its Mental Health Procedures and Administration Committee. The Conference membership, by a vote of 224 to five, endorsed a statement of position, which read as follows:

> "As Judges, we are keenly aware that a hardcore of extremely disturbed and dangerous offenders is inherent in the criminal system. For them, the only alternative to incarceration is a maximum security mental health facility."

In regard to Farview State Hospital, the statement said:

> "We have been given no reason to believe that any substitute facilities will be made available. We cannot accept expressions of hope or promises. We cannot utilize facilities that are less than maximum security if we are to continue to discharge our obligation to the public."

By resolution, the Conference strongly opposed "the closing the Farview State Hospital in the absence of the establishment of other maximum security facilities suitable for the care and treatment of the mentally ill." This position was reaffirmed at a meeting of the officers and executive committee of the Conference on October 8, 1977.

Trial judges occupy a unique vantage point from which to observe the correctional system and the mental health system. They also are charged with the special responsibility of applying the law so as to protect both the individual and the community. In their work, they are required to deal with the many-sided and often difficult issues and the competing interests and needs affecting the mentally ill offenders - whose criminal record may include repeated acts of serious violence or who may be disabled and virtually helpless.

Given this background, a trial judge's first order of business, however, is to decide what must be done in a particular case, sometimes under emergency conditions, and always in the light of what is most just and practical. The safety and welfare of the citizens of the State cannot be ignored or depreciated in the name of trying to compel the Commonwealth to provide better care and treatment service in the future. Where the need is great and the choices are few, a judge must choose the best alternative available. The choice, at present, is therefore an easy one. So long as Farview State Hospital remains the only reliably secure mental health facility in Pennsylvania, trial judges are overwhelmingly in favor of keeping it in operation. To this extent, I join with other members of the Task Force in their expressions of similar views.

APPENDIX I*

The Alliance of the Liberation of Mental Patients

Michael Basista, Esquire
Columbia and Montour County Court of Common Pleas

Richard Bazelon, Esquire

Dr. Vincent Berger, Director
Regional Psychiatric Forensic Unit, Mayview State Hospital

Lloyd Brackwell
Former Farview Patient

Judge Beryl Caesar
Philadelphia Court of Common Pleas

Dr. Joaquin Canals
Norristown State Hospital

Walter Cohen, Esquire

Gerald Cooke, Ph.D., Chief Psychologist
Norristown State Hospital

Rendell Davis, Executive Director
Pennsylvania Prison Society

William Davison
Northampton County Probation Officer

Allen Deibler, Administrator
Lehigh County MH/MR Program

Judge John C. Dowling
Dauphin County Court of Common Pleas

The Honorable D. Michael Fischer
House of Representatives

Mahmood Ghahramani, M.D.
Philadelphia State Hospital

Ronald Gibson
Former Farview Patient

Ray Hamill, Esquire
Representative Farview Patient Body Government

Elsie Heard
Philadelphia District Attorney's Office

Dr. Robert Hickey
ACLU, Pittsburgh

Glenn Jeffes, Superintendent
CHASE Correctional Institution, Dallas

Terry Johnson
Pennsylvania Prison Society

Ned Levine, Esquire
Philadelphia Public Defender's Office

Dr. Richard Mays, Medical Director, Divine Providence Community Mental Health Center, Williamsport

James Moore, Vice President
Western Wayne Landowners and Taxpayers Association, Inc.

Judge Jay Myers
Columbia and Montour County Court of Common Pleas

Robert Nappi
Mental Health Association of Lackawanna County

Joseph Radley
Lycoming/Clinton County MH/MR Center

Ronald Refice, Ph.D.
Director of Social Rehabilitative Services
Farview State Hospital

William B. Robinson, Commissioner
Bureau of Correction

Dr. Jack Roop, Superintendent
Allentown State Hospital

Frank Schubert
Council Director for District Council 87 of AFSCME

Andrew Schneider, Esquire
ABA Monitoring and Advocacy Project

Richard Sheehan
Mental Health Review Officer (Norristown)

Hilda Silverman
Pennsylvania Program for Women and Girl Offenders

William Sipes
Former Farview Patient

Maxine Stotland, Esquire
Philadelphia District Attorney's Office

Robert Switzer, M.D. Superintendent
Eastern State School and Hospital

Ronald Thomas
Former Farview Patient

Margery Velimesis
Pennsylvania Program for Women and Girl Offenders

Mr. Jonathan Vipond
Mental Health Association of Pennsylvania

This list represents those individuals formally presenting oral testimony to the Task Force.

APPENDIX II

FORENSIC UNITS–CURRENT STAFFING AND CENSUS

	Northeast Region	Southeast Region		Western Region	
	Farview	PSH N-8	Norristown	Mayview	Warren
Bed Capacity	475	44	75 closed + 10-12 forensic pts. open ward	56	30
Census as of 9/8/77	176	40	70	42	22
Security Rating	Maximum	Medium	Medium	Medium	Medium
Staff:					
Psychiatrists	1f/t 2p/t	1	1	20hr	1
RNs	29	3	5	10	5
P.S.A.s	254	26	63	30	19
Social Workers	6	1	2½	3	1
Psychologists Psychology Interns	8	60hr	98hr	80hr	20hr
Ministers	4	1p/t	30%	0	10%
Occupational Therapists Therapeutic Activities Workers Recreational Therapists	12f/t	28½hr	45hr	120hr	80hr
Custodial Workers	0*	2	3	2	0
Clerk-Secretary	20	0	0	0	0

*For this classification at Farview, 44 CETA employees principally perform this function. Also as Farview is an institution to itself, it has many other job classifications of employees, with total staff complement being 493 as of 9/13/77.

APPENDIX III

Disposition of Mentally Ill Offender

EDWARD B. GUY
MELVIN S. HELLER
SAMUEL POLSKY

THE MENTALLY ILL OFFENDER deserves the best possible psychiatric care and treatment, particularly when involved in criminal litigation; and society deserves the very careful appraisal and management of his potential for dangerousness.

For pragmatic as well as humanitarian reasons, it is imperative that the mentally ill offender be handled skillfully and expeditiously at all levels of the legal process. A number of definitive consequences flow from this requirement.

To begin with, it is necessary that the law, as set forth in the appropriate Mental Health and Retardation Acts or other statutes, be clear and concise. It is equally important that the necessary diagnostic and treatment facilities be available: a law that cannot be implemented is worse than useless—it is a deception. Furthermore, any program, however well conceived and supported, must fail if its administrative machinery does not provide for swift and easy transfer from one facility or operational level to another. Finally, the purposes and implications of diagnosis and treatment at each stage of legal inquisition or disposition must be clearly understood by the judiciary as well as the attorneys, if the statutory procedures are to be used effectively and well.

Mental illness has a pervasive influence, sometimes unrecognized and often neglected in the criminal law, including: determination of competency in each phase of proceedings, from the pre-trial stage to the execution of sentence; problems of exculpatory insanity; reduction in grade of offense; diminished responsibility; mitigation of punishment; and alternatives to a prison sentence. These varied considerations, in turn, must often take into account the individual's need for special external controls, psychiatric treatment, and special rehabilitative considerations. Perhaps most neglected are the dispositional judgments that are made outside the formal courtroom setting but are essential interstitial parts of the administration of justice.

Attempts to improve the management of mentally ill offenders raise two basic considerations. The first involves the more efficient utilization of existing personnel and facilities, and the second lies in expansion in critically needed areas. Until the most efficient use is made of what we already have, we are hardly justified in asking society for more.

From a realistic and pragmatic point of view it is not likely that our society will reorder its priorities in the immediate future and devote a significantly larger portion of its resources to the care and treatment of the mentally ill, and especially not to the mentally ill offender. Neither the professionals currently working in the field, nor the offenders or their families, have any great influence on our legislators, and certainly no lobbies are working on a federal or state level to increase spending in this area. We must, then, within the field itself, devote our first efforts to the more efficient utilization of existing staff and facilities.

The basic psychiatric needs fall roughly into two broad areas—diagnostic and treatment, each requiring a specialized staff and physical facility.

The average psychiatric professional is not equipped through training or experience to deal effectively with the mentally ill offender whose socio-cultural background, values, behavior, thoughts, and feelings are so different from those of the average patient encountered in psychiatric practice. The forensic psychiatric questions which arise in these cases also require a special understanding of the legal aspects of the case and the various dispositional possibilities which are open.

Similarly, the average psychiatric hospital facility is not staffed or physically equipped to deal with the special considerations of maximum security and special handling which these criminally inclined and mentally ill persons require.

Legislation in most states provides a reasonably comprehensive mental health and mental retardation act, which serves as the framework for all the activities concerning the disposition of the mentally ill offender. These acts in the United States tend to follow a common pattern. In consequence they share characteristics that lead to common problems.

First, the acts are designed primarily for civil commitment, and criminal commitment becomes a peripheral, rather than a central part of the act's design.

Second, the distinction between civil and criminal commitment represents a normative and administrative convenience rather than an operative reality. The line between civil and criminal conduct leading to commitment is often blurred for a variety of reasons. In addition the distinction between criminal and non-criminal behavior turns upon the determination of a state of mind more or less recently antecedent to the behavior that leads to the commitment. There is an obvious circularity here that is difficult to escape.

Third, protection of the individual's civil rights, including due process and the determination of his state of mind, is very uneven. Where a mental health act spells out such protections, it is apt to do so in greater detail with respect to criminal commitment than for civil commitment. Furthermore, some of the basic protections are not spelled out in mental health acts, but are part of the greater complex of constitutional law. Mental health acts assume that the best interests of society and the best interests of the individual coincide. This is often far from the fact, and an adversary procedure may not be the best way to determine an optimum balance between the two conflicting interests.

Fourth, commitment in lieu of sentence poses special problems of its own. It is an admirable enlargement of judicial discretion to permit an individual to be treated as sick after he has been found guilty. It is also a double valued system that, to some extent, contradicts itself in operation. The indefinite commitment appropriate to civil cases cannot be utilized. The offender has the right to be freed or to have his criminal commitment converted into a civil commitment after he has served an appropriate sentence. This tends to result in commitment for a specific number of years, rather than for the period of therapeutic necessity, which cannot be determined in advance.

The director of the mental health facility faces several handicaps in dealing with criminal commitments for a fixed period of years. Security requirements frustrate his ability to mix such individuals with general hospital population and interfere with their integration into the general therapeutic program of the hospital. When the individual is well enough to be released completely or when it would be therapeutically effective to release him for home visits, this cannot be done readily without the complexities of judicial approval, since the individual is still a court case.

A reasonably comprehensive mental health act, in providing for commitment to mental facilities under a variety of specific situations and conditions, must address itself to the broad considerations of voluntary and involuntary civil commitment, emergency examinations, emergency and indefinite involuntary commitments, and criminal commitments under such circumstances as pre-trial cases on bail and in detentioner status, pre-sentence cases requiring psychiatric examination and/or care and treatment, and sentenced individuals in correctional institutions or committed to mental health facilities in lieu of sentence. The act must provide for the expeditious transfer of the individual case to the most appropriate facility; be it a correctional or psychiatric one, and must provide for the re-transfer of the individual when the appropriateness of the commitment changes.

In dealing with mentally ill offenders, the responsible persons in the legal process range from the arresting police officers through the courts and correctional institutions, to the post release Probation or Parole departments. Despite the differences in training and experience, all must address themselves to both the legal and psychiatric components of each case.

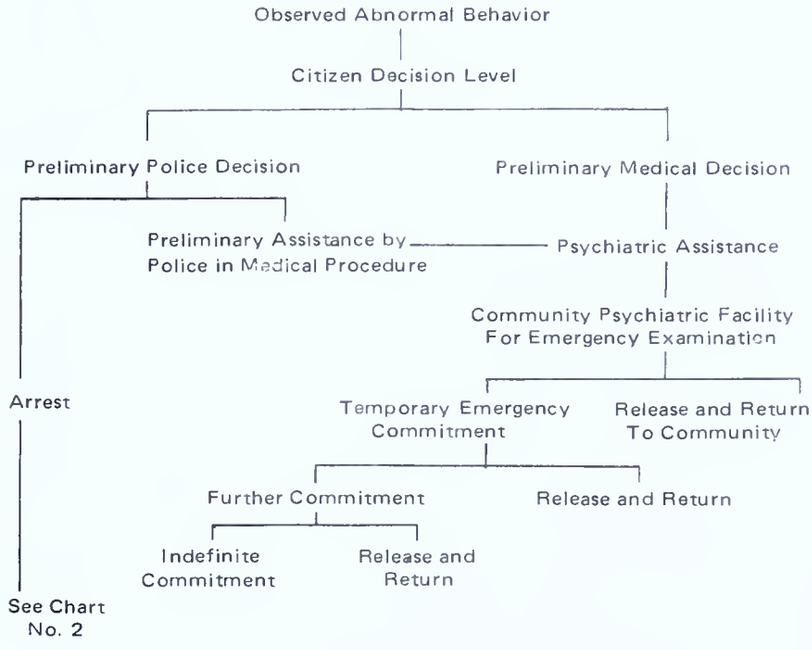
The four appended charts represent diagramatically the integration of the legal and medical-psychiatric components of a case as it proceeds

from the initial citizen decision level through the various court and correctional institutional proceedings.*

Chart Number One: When a citizen observes an act of abnormal behavior he is faced with the first of what may become a long series of "clinical" decisions. The particular act of observed behavior may or may not represent a criminal act, and he must decide where to turn for help. This decision involves two basic choices; one, police and arrest proceedings, and two, medical assistance.

If the citizen decides to call the police, the investigating officers make a second clinical decision—whether to proceed with the legal arrest or whether to render assistance in securing psychiatric help in the case.

CHART NUMBER ONE



Where the citizen has elected to proceed along lines of medical assistance, he may involve the family doctor, minister, social agency, or lawyer. If a psychiatric examination is deemed necessary, the mental health act must make provision for such an emergency examination: it is best carried out at a community psychiatric facility.

The examining psychiatrist makes one of two essential decisions. He may decide that an emergency or temporary commitment to a mental health facility is necessary and may institute the necessary commitment proceedings. On the other hand, he may decide that there are no indications for psychiatric hospitalization, in which case the individual is released and returned to the community.

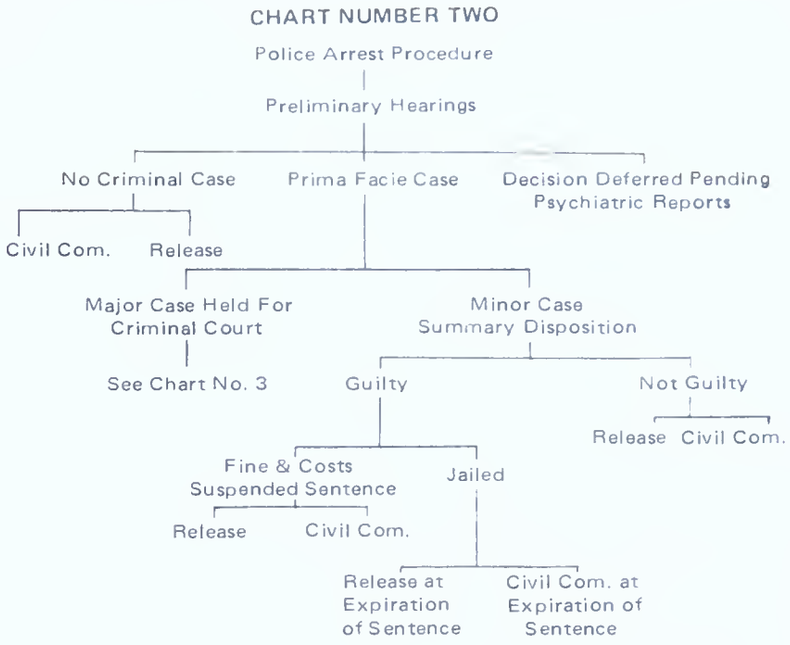
If emergency commitment has been instituted, a further decision regarding its continuance must be made at the end of this temporary period. Here the two choices are indefinite commitment to a mental health facility, or release and return to the community.

Chart Number Two: This outlines the various steps in the disposition of major and minor cases when the police are called and arrest proceedings are instituted. After the formal arrest procedures, a series of preliminary hearings may result in one of three conclusions.

First, it may be determined that there is no significant criminal case and the individual is discharged from the criminal process. If, however, there seems to be significant evidence of mental illness, the case may be referred to an appropriate psychiatric facility as indicated on Chart One.

Second, legal decision may be deferred at this stage, pending emergency psychiatric evaluation and commitment if necessary. In

CHART NUMBER TWO



such case, there will continue to be a criminal detainer against the individual.

Third, a prima facie case may be established. Major cases which will be held for criminal court are outlined under Chart Three.

In minor cases, there may be a summary disposition at the municipal court level. Two basic outcomes are possible. One, a not guilty finding, in which case the criminal proceedings are ended, and the individual could be released to the community. If, however, there is significant evidence of mental illness, it may be referred into the general psychiatric dispositional channel for possible civil commitment. In the event of a guilty finding, two possibilities are open. Fine and costs or suspended sentence may be assigned and the individual could be returned to the community. Again the psychiatric aspects of the case may be handled through civil procedures if necessary. If the individual is jailed, his psychiatric care becomes the responsibility of the institutional psychiatrist. At the conclusion of his jail sentence he would either be released to the community or, if further institutional care is needed, he could be re-introduced into the civil psychiatric commitment proceedings.

Chart Number Three: Major cases held for criminal court present two immediate possibilities for disposition. One a guilty plea, and the other a not guilty plea. In the event of a guilty plea, three possibilities are open. The first would be a fine and cost or suspended sentence disposition, which would then open the way for the handling of the psychiatric components of the case under civil proceedings by either commitment to a facility for care and treatment or out-patient treatment as a condition of probation. The second possibility would be a commitment to a mental health facility for care and treatment in lieu of a criminal sentence. This commitment, under these criminal proceedings, could not be for a period of time longer than the maximum sentence for the crime involved. If during this commitment period the director of the mental health facility determines that the individual no longer requires his institutional care, he can petition the court for a transfer of the patient to a correctional facility. At the expiration of the commitment period the director of the facility may, in appropriate cases, institute indefinite civil commitment proceedings and retain the individual in his institution. The third possibility is imprisonment in a correctional institution. The Pennsylvania Mental Health Act makes provision for the transfer of individuals from correctional institutions to mental health facilities in appropriate cases. While imprisoned, the psychiatric aspects of the case are handled by the prison medical staff. At the expiration of the sentence period, the individual may be released to the community. In rare cases requiring further psychiatric care, civil proceedings can be instituted.

**These charts are keyed to Pennsylvania law. For a more detailed description, see Temple University Unit in Law and Psychiatry, Standard Legal Procedures in the Disposition of Mentally Ill Offenders, 1969, 30pp.*

In the event of a not guilty plea, two possibilities are open for the disposition of the criminal components of the case. The charges may be nolle prossed at this level and, in appropriate cases, civil commitment procedures instituted, either for in-patient or out-patient care. The other dispositional channel, through grand jury indictment and arraignment, can result in four resolutions. *One*, the indictment may be quashed, again opening the way for civil psychiatric proceedings. *Two*, the individual may enter a guilty plea which then re-introduces the possibilities as already described under guilty plea. *Three*, a not guilty plea resulting in trial, in which case findings will be either not guilty or guilty. In the event of a not guilty finding, the individual may be released to the community or, in the presence of evidence of serious mental illness, civil psychiatric commitment proceedings can be instituted. If the individual is found guilty and is sentenced, the possible psychiatric implications of the case would be the same as under a guilty plea above. The fourth possibility is that the proceedings will be nolle prossed, in which case the individual may be released to the community or, as above, civil commitment proceedings can be instituted.

Chart Number Four: This chart outlines the utilization of available psychiatric facilities, both diagnostic and therapeutic. In the adversarial situation, either side may at any time ask for and secure their own private psychiatric evaluations. Based on these determinations, recommendations can be made to the court for disposition of the case. The court itself, however, should have available a psychiatric division within the general court structure, or at the very least there should be court appointed psychiatrists to act as consultants to the court and make recommendations for appropriate disposition of mentally ill persons.

Any interested and responsible person may petition the court for the psychiatric examination of the defendant by the court psychiatrist. The court may order such an examination and the reports should be addressed to the ordering judge. It should be his discretion to distribute the reports to the involved persons or agencies.

If the psychiatric division, or the appointed psychiatrist, is ordered by the court to examine a defendant, there are three basic possibilities which may present themselves. *One*, there will be a finding of no significant mental disability, in which case the individual will probably be found competent to proceed with trial, sentencing, and imprisonment if found guilty. Unless there is some intervening psychiatric situation during the process, the individual would be released back to the community at the conclusion of the sentence. If during the course of the sentence, a significant psychiatric situation intervenes, then the court should be petitioned for further psychiatric examination. Based on the recommendations of the examining psychiatrists, certain requests for transfer and re-transfers into and out of mental health facilities may be instituted. *Two*, the examining psychiatrist will be of the opinion that further psychiatric observation in a mental health facility is indicated before a definitive psychiatric opinion can be expressed. The Mental

CHART NUMBER THREE (a)

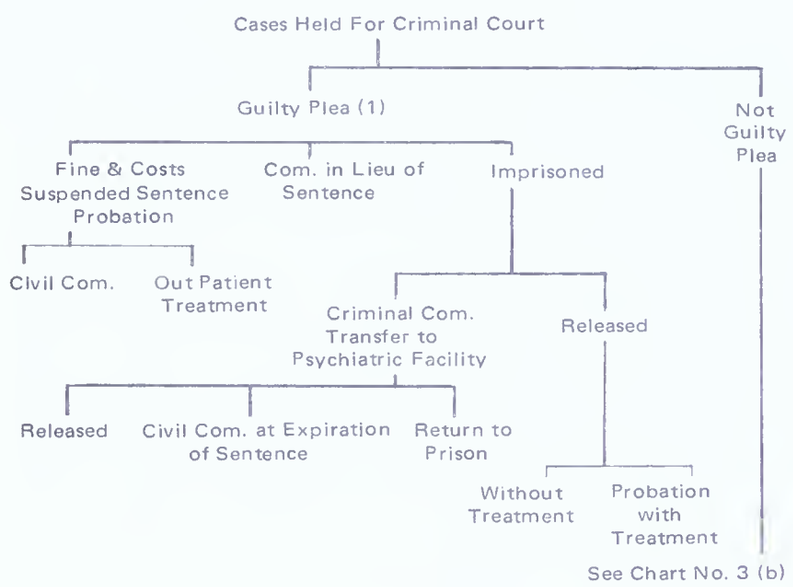


CHART NUMBER THREE (b)
(Cases Held For Criminal Court)

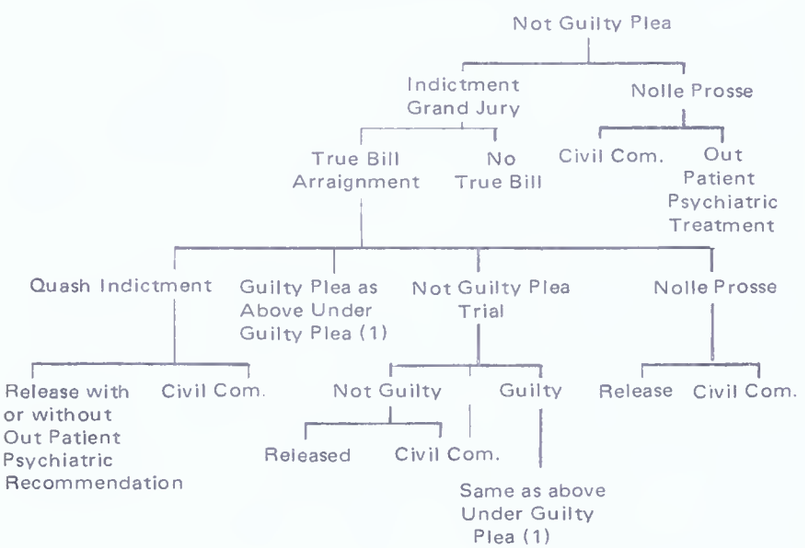
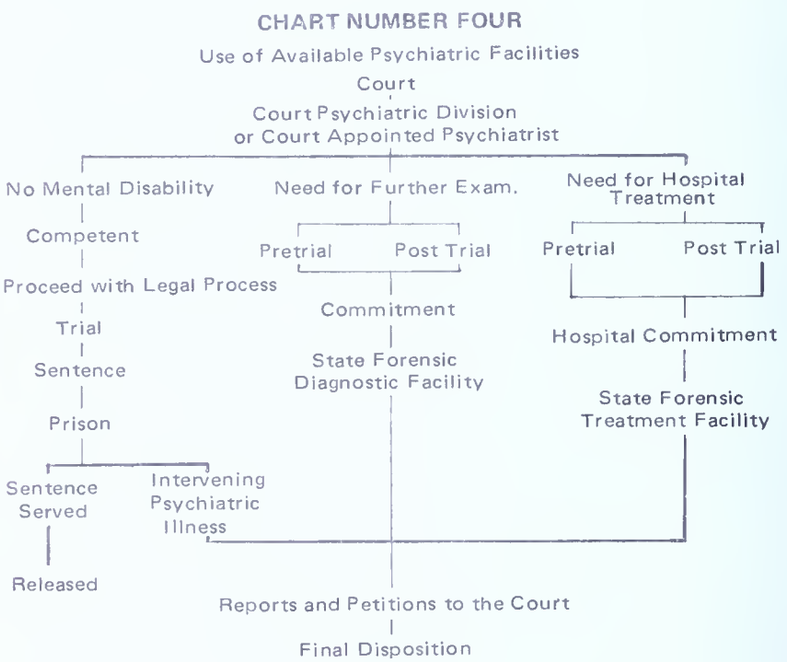


CHART NUMBER FOUR



Health Act should provide for the handling of both pre-trial and post-trial cases requiring further examination and commitment proceedings. These cases requiring extensive forensic psychiatric appraisal are best handled in institutions which are both staffed and physically equipped to deal with the special problems involved. These commitments are usually for limited periods of time—for example in Pennsylvania, for not more than sixty days. At the conclusion of this period of time the definitive psychiatric report is submitted to the court for its consideration in the further disposition of the case. *Third*, the examining psychiatrist will determine that hospital treatment is necessary, in which case the mental health act must make provision for the handling of pre-trial and post-trial cases requiring prolonged hospital treatment. The director of the hospital facility should inform the court of any change in the condition and requirements of the individual. As in the case of specialized diagnostic facilities, it is necessary that these treatment facilities be staffed and physically equipped to handle the special requirements for maximum security as well as treatment. In some cases it is possible that these individuals can be handled in the usual state hospital facility, but special institutions are often necessary. It should be the responsibility of the mental health officials to recommend to the court the most appropriate institution. These hospital authorities will make reports to the court, request transfers and re-transfers, and assist the court in arriving at a final disposition in the case.

Summary: There are serious defects in legal and psychiatric understanding of mental illness and its influence on criminal behavior. Increasing research, experience, and effort is slowly expanding our knowledge.

Present knowledge in the field is often not effectively utilized in the treatment and disposition of mentally ill offenders because of the poor integration of existing legal and psychiatric facilities. We have attempted to outline the basic legal and psychiatric requirements, both professional and structural, of a meaningful system, and have established flow charts, which trace the progression of cases through the legal process and show the integration of psychiatric diagnostic and treatment facilities into this legal process.

APPENDIX IV

PREAMBLE

The Legislature of the Commonwealth of Pennsylvania does hereby acknowledge that the mentally ill criminal offender presents a sufficient threat to the citizens of the Commonwealth of Pennsylvania to require special treatment and procedures where crimes involving the killing of human beings are involved.

This law acknowledges not only the right that a person who is mentally ill is entitled to receive humane treatment to aid him in recovering from his mental illness, but also the right of a free society to protect itself from the dangers of those persons who kill other citizens while insane or suffering from mental disease or defect.

It is likewise acknowledged that the prospect of using mental illness as an excuse for killing is unwise and may lead to feigned abuses. The Commonwealth of Pennsylvania does hereby demand that all persons shall be responsible for the consequences of taking the life of a human being.

BILL No.

KILLING WHILE INSANE:

It shall be unlawful for any person to kill or cause the death of another human being under any of the following circumstances:

a. While legally insane, or

b. While suffering from any unsafe mental condition, disease or defect that prevents the offender from fully apprehending, knowing and intending the consequences of his behavior or acts.

This offense shall be known as killing while insane and shall specifically be declared to be a "malum prohibitum" offense.

PROCEDURE:

Upon a finding of guilty of this offense, the defendant shall be sentenced to be confined in a state correctional institution or such other state institution as deemed appropriate by the Commissioner of Mental Health for a period of five (5) years to life.

The sentence shall be imposed by the trial court following a trial which shall be limited to the question as to whether or not the defendant in fact killed another human being. This crime may be charged in the same proceeding as the charge of criminal homicide and must be proven beyond a reasonable doubt in the same manner and same form as such other criminal charges.

At the end of five (5) years, the Commissioner of Mental Health shall act as Chairman of a Board comprised of two other psychiatrists, one elected district attorney, a defense lawyer and a member of the Board of Probation and Parole; all of whom shall be appointed by the Governor. This board shall evaluate the prospect of the defendant's propensity to commit future acts of violence, and if:

a. The Board unanimously agrees that it is extremely unlikely for the defendant to repeat his past acts; and if he is not required to take medication in order to maintain a normal mental condition, he shall be released on parole and be subject to such probationary conditions as may be established by the Parole Board.

b. If the Board unanimously agrees that it is likely that the defendant will commit future acts of violence, he shall be recommitted for one (1) year; and his case shall be reviewed every year to determine when he may be released to society in accordance with the standards set forth herein.

c. If the Board agrees that the defendant may be released to society and be an unlikely candidate for repeated future acts of violence through the compulsive taking of medication, the said defendant may be released on the strict condition (in addition to any other probation requirement) that he be required to appear and accept medication at such reasonable times as is deemed medically proper and necessary. A refusal of the defendant to comply with this procedure shall cause the immediate recommitment for one (1) year, after which time his case may be reviewed to determine when he should be released.

d. If the majority of the Board agrees that the defendant poses some prospect of harm to others, he may nonetheless be released upon such conditions as the Board deems reasonable to assure that the defendant's release from confinement presents a minimal threat to society. A person who is released under this fashion who, in fact, kills or severely injures another person shall be immediately recommitted upon a finding that he has committed such harm by a Court of competent jurisdiction and thereafter shall not be eligible for release until the conditions of subsection a may be complied with.

APPENDIX V[1]

A recent study by the Joint Economic Committee of the United States Congress[2] determined that by the end of the decade it is estimated that current employment will result in deaths and institutional admissions nearly three times larger than shown below in this table.

CUMMULATIVE IMPACT OF THE 1.4 PERCENT RISE IN UNEMPLOYMENT DURING 1970

Social Stress Indicator	Stress Incidence 1975	Change in stress Indicator for a 1.4 Percent Rise in Unemployment	Increase in Stress Incidence Due to the Rise in Unemployment
Suicide:	26,960	5.7%	1,540
State Mental Hospital Admission:	117,480[3]	4.7	5,520
State Prison Admission:	136,875[4]	5.6	7,660
Homicide:	21,730	8.0	1,740
Cirrhosis of the Liver Mortality:	32,080	2.7	870
Cardiovascular-Renal Disease Mortality:	979,180	2.7	26,440
Total Mortality:	1,910,000	2.7	51,570

Between 1926 and 1962 admissions to State prisons for the entire United States were positively correlated with the unemployment rate. Two points require attention in our consideration of unemployment and population projections:

1. The unemployment rate has a fluctuating pattern over time which tends to be cyclic in nature. The distribution of economic trauma would be wave-like rather than linear, e.g., overtime pathological reactions to economic trauma build up, reach a high point and then decline. Also, "height of the wave", e.g., higher levels of unemployment seem to have considerably more deleterious effect on percent changes in the stress indicators.

2. The effects of economic recession upon social stress indicators varies for different subgroups of the population. The effects of structured unemployment and cyclic unemployment seem to be particularly damaging to minorities and youth. The economic growth of the last two decades has not affected greatly the economic condition of a substantial proportion of inner city residents. Unemployment and subemployment have been especially severe for youths and minorities. (August, 1977, U.S. Department of Labor Statistics show 40.4% of black teenagers are unemployed [compared to 14.7% white] and 34% of the 18-24 black males.)[5]

Clearly, fluctuations, levels and duration of unemployment, particularly for youths and minorities, all affect prison admission rates. Further, the full social consequences of adverse economic conditions may have a time lag of two years or more. It seems realistic to conclude that employment affects, besides the homocide rate, other personnel violent crime rates. But little information is available on increases in the numbers of violent crime commissions or the resulting numbers of persons requiring maximum security psychiatric care due to changes in unemployment rates.

[1] *Brenner, Harvey, "Estimating the Social Costs of National Ecomonic Policy: Implications for Mental and Physical Health and Criminal Aggression", Vol. 1 — Employment, Paper No. 5, U.S. Government Printing Office, October 26, 1976. Pg. vii.*

[2] *Ibid.*

[3] *1972 date, age 65 and under.*

[4] *1974 data.*

[5] *Flanagan, p. 36: "Zimring (1975) concludes that the number of urban non-white males, ages 18-20, will increase until 1980, will decline about 6% between 1980 and 1985 and will return to the 1980 level by 1990. In terms of the peak prison ages of 23-25, this means an increase until 1985, a 6% decrease between 1985 and 1990, and a return to the 1985 level by 1995.*

APPENDIX VI

PSYCHIATRIC SERVICES AVAILABLE IN BUREAU OF CORRECTION

Institution	No. of Inmates Physically Present as of March, 1977	No. of Psychiatrists	Hours Per Week
SCI Camp Hill	1,102	1	12
SCI Dallas	844	1	6
SCI Graterford	1,848	2	21
SCI Huntingdon	1,026	1	16
SCI Muncy	224	1	4
SCI Rockview	884	1	20
SCI Pittsburgh	1,042	2	16
RCF Greensburg	214	0	0
		9	95

Bureau of Correction population 7,763 inmates.

It should be noted that because of commutation evaluations, other program evaluations (pre-parole, pre-release, furloughs, etc.) and if medication reviews are excluded, it is estimated that our psychiatrists average only 13 to 15 treatment contacts per month.

NUMBER OF PETITIONS SUBMITTED TO THE COURT, NUMBER OF INMATES COMMITTED TO MENTAL HOSPITALS, NUMBER OF INMATES RETURNED BY THE COURT FOLLOWING COMMITMENT HEARINGS

SEPTEMBER 1976 – MAY 1977

Number of Petitions Submitted		Number Committed	Number Returned Non-Committed
SCI Camp Hill	0	0	0
SCI Dallas	7	6	1
SCI Graterford	16	13	3
RCF Greensburg	3	3	0
SCI Huntingdon	8	7	1 *committed later date
SCI Muncy	0	0	0
SCI Pittsburgh	13	7 4 pending	2
SCI Rockview	0	0	0
TOTAL	47	36	7

NUMBER OF PSYCHOLOGISTS ON STAFF IN THE STATE CORRECTIONA'. INSTITUTIONS AS OF MAY 1977

		Psychologist	Psychological Services Associate
SCI Camp Hill	Institution	1	1
	*DCC		2
SCI Dallas		1 (½ time)	1
SCI Graterford	Institution	1	
	DCC	1	3
SCI Huntingdon		1	1
SCI Muncy			1
SCI Pittsburgh	Institution	1	1
	DCC		2
SCI Rockview			1
RCF Greensburg			1
TOTALS		6	14

**DCC — Diagnostic and Classification Center*

The primary function of DCC psychological staff is the diagnosis and classification of all new admissions to the Bureau and therefore, they have very little or no time for treatment activities. Thus we have a total of 12 psychological personnel (5 Psychologists and 7 Psychological Services Associates) available for treatment services. Out of these 12, the PSA's at SCI Muncy (1) and RCF — Greensburg (1) carry a dual function of initial assessment of commitments received at their respective institutions as well as treatment responsibilities. The nine remaining institutional psychological personnel are responsible for commutation evaluations pre-parole evaluations, pre-release and furlough evaluations, as well as routine program requests for evaluations. Thus the time they have available for treatment activities (i.e. individual therapy, group therapy, working with emotionally or behaviorally disturbed inmates, crisis intervention, etc.) is very limited. It is estimated that over the system as a whole our psychological personnel have approximately 15% of their time available for direct treatment activities.

NUMBER OF INMATES CONFINED IN BEHAVIOR ADJUSTMENT UNIT*

Number in BAU 3/77**

	Maximum Security	Administrative Segregation
SCI Camp Hill	31	59
SCI Dallas	11	17
SCI Graterford	35	41
SCI Huntingdon	24	36
SCI Pittsburgh	30	36
SCI Rockview	14	11
RCF Greensburg	2	3
SCI Muncy	—	12
TOTAL	147	215

**Figures represent the number of individuals confined in BAU as of March 31, 1977.*

***BAU — as used here refers to placement in a secure unit within the institution with restricted movement from general population providing closer supervision and protection.*

CRIMINAL STATUS CLASSIFICATIONS FOR FORENSIC UNITS

As of May, 1977

Farview

Total number of patients – 186

Criminal Status:

7	– Not guilty – insanity
62	– Incompetent for trial
46	– Observation
51	– Undergoing sentence
9	– Unable to determine
0	– Not available

Philadelphia

Total number of patients – 33

Criminal Status:

0	– Not guilty – insanity
22	– Incompetent for trial
5	– Observation
10	– Undergoing sentence
1	– Unable to determine
0	– Not available

Mayview

Total number of patients – 56

Criminal Status:

1	– Not guilty – insanity
8	– Incompetent for trial
3	– Observation
11	– Undergoing sentence
29	– Unable to determine
0	– Not available

Warren

Total number of patients – 26

Criminal Status:

1	– Not guilty – insanity
3	– Incompetent for trial
13	– Observation
3	– Undergoing sentence
0	– Unable to determine
6	– Not available

Norristown

Total number of patients – 82

Criminal Status:

4	– Not guilty – insanity
6	– Incompetent for trial
5	– Observation
46	– Undergoing sentence
21	– Unable to determine
0	– Not available

TOTALS

13	– Not guilty – insanity
101	– Incompetent for trial
72	– Observation
121	– Undergoing sentence
60	– Unable to determine
6	– Not available

Manual of STANDARDS for Adult Correctional Institutions



COMMISSION ON ACCREDITATION
FOR CORRECTIONS

Sponsored by the
AMERICAN CORRECTIONAL ASSOCIATION



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In the event of suicide, homicide, accidental death or death under suspicious circumstances, the chief executive officer also should notify the coroner and appropriate law enforcement officials.

4271 Personnel who have received training in emergency first-aid procedures are available on each shift. (Essential)

DISCUSSION: Emergency first-aid may be required at any time by an inmate or an employee. Personnel who have received training in emergency first-aid should therefore be available on each shift. Also, first-aid supplies should be available at key points in the facility.

4272 There are written plans for providing emergency medical care at any location of the institution; these plans also specify the method and route of transporting patients to the hospital. (Essential)

DISCUSSION: Along with the various emergency plans the institution maintains, e.g., for fire, riots, etc., emergency plans should be developed to provide inmates and personnel prompt medical care and transportation to the hospital from any location in the institution.

4273 In institutions for women, there are medical services to meet the special health care needs of women. (Essential)

DISCUSSION: Obstetrical, gynecological, abortion, family planning, health education and child placement services should be available as needed.

4274 Administrative policy provides for housing and programs for disabled and infirm inmates in facilities appropriate to their needs. (Essential)

DISCUSSION: Disabled and infirm inmates require separate housing in facilities that are conducive to their program needs.

4275 Written policy and procedure govern the treatment of inmates with severe emotional disturbances. (Essential)

DISCUSSION: Many emotionally disturbed inmates are prone to violent and destructive behavior and are oriented toward escape. While severely psychotic inmates should be transferred to state hospitals, less disturbed inmates should be retained in the general inmate population, where possible, and provided treatment programs that are supervised by competent mental health professionals and that utilize the least coercion necessary.

4276 Where there are separate living units for inmates with severe emotional disturbances, an interdisciplinary team is assigned to these living units. (Essential)

DISCUSSION: All staff members responsible for providing services in a living unit for emotionally disturbed inmates should be integrated into a multidisciplinary team and should be under the direction and supervision of a professionally trained staff member. Consistency in approach and treatment is essential for the

emotionally disturbed inmate, and a team approach that includes regular meetings ensures that the treatment given these inmates is intensive, coordinated and direct.

4277 Written policy specifies that appropriate facilities are available for inmates who are diagnosed by qualified psychiatrists or psychologists as severely psychotic. (Essential)

DISCUSSION: Psychotic inmates should be transferred to mental health institutions. However, many state mental hospitals are becoming more open and are resisting the admission of disturbed inmates for whom secure housing is required. Partly in response to this, state correctional systems have begun to develop their own psychiatric facilities. Whatever system prevails, psychotic inmates should be transferred to a facility that can treat them effectively and assure public safety. These facilities must be under the supervision of mental health personnel and operated according to the standards and procedures of the psychiatric field.

4278 Written policy and procedure specify that qualified psychological and psychiatric personnel provide services for inmates diagnosed as severely mentally retarded. (Essential)

DISCUSSION: Severely mentally retarded inmates should be placed in facilities specially designed for their treatment. If they cannot be placed in such facilities outside the correctional institution, the institution should provide adequate services for their health, development and protection of their dignity. Where possible, programs should provide for their continued physical, intellectual, social and emotional growth and should encourage the development of skills, habits, and attitudes that are essential to adaptation to society.

4279 Psychiatric consultation is available for the management and treatment of inmates with special needs. (Essential)

DISCUSSION: A qualified psychiatrist should always be available to assist the trained mental health personnel who are responsible for the day-to-day management of inmates with special needs. Depending upon the size of the institution and the number and type of inmates classified as special needs inmates, the psychiatric services may range from one or more full-time staff psychiatrists to one part-time consulting psychiatrist. Whatever the arrangement, this service should be available 24 hours a day.

Inmate Rights

4280 Written policy and procedure ensure the right of inmates to have access to courts. (Essential)

DISCUSSION: Inmates should have the right to present any issue, including challenging the legality of their conviction or confinement; seeking redress for illegal conditions or treatment while under correctional control; pursuing remedies in connection with civil legal problems; and, asserting against correctional or other government authority any other rights protected by constitutional or statutory provision or common law.

APPENDIX VIII

The Bureau of Correction has suggested the following kinds f cases needed to be transferred from the correctional system to ıe mental health system:

1. The severely mentally ill who are a danger to themselves or others (e.g., the actively suicidal, the person who is assaultive on the basis of a delusional system, etc.).

2. Those individuals who are so severely mentally ill they cannot adequately care for themselves (e.g., chronic or acute psychotics).

3. The severely depressed individual who, although he has not made an overt suicidal gesture, is a high suicidal risk (particularly those cases that do not respond rapidly to medication).

4. Those individuals who are clearly psychotic but are not dangerous to themselves or others (i.e., they have not committed any acts of violence and are able, in the structured setting of an institution, to care for themselves), but who may be paranoid, delusional or have a very tenuous hold on reality.

5. Persons suffering severe brain damage that is accompanied by psychosis.

6. Persons suffering from senile psychosis.

APPENDIX IX

OA-501 1-67 COMMONWEALTH OF PENNSYLVANIA

SUBJECT Legislative Recommendations of the Task Force

TO Members of the Governor's Task Force on
Maximum Security Psychiatric Care

FROM Robert P. Kane
Attorney General

I have reviewed the Legislative Recommendations of the Governor's Task Force on Maximum Security Psychiatric Care as set forth in the attached draft Report. These proposals, as I understand them, represent policy responses to the mandates of the Governor's Executive Order and, in this regard, my views as a member of the Task Force have previously been received and considered.

My present remarks concern certain purely legal and constitutional ramifications of the Legislative Recommendations and are submitted to you in my official capacity as Attorney General. I am submitting my observations to you in this form and at this time for the reason that I may be called upon at some later time to render an official opinion or opinions concerning the legal and/or constitutional aspects of such proposals and, accordingly, I feel it is appropriate to bring to your attention the following comments regarding certain of the recommendations. I must emphasize, however, that the within observations are just that -- that is, observations only -- and in no way represent binding legal conclusions or advice. Such conclusions and advice are specifically reserved for inquiries, appropriately made, in a non-abstract context which permits of an adequate opportunity to achieve the definitive conclusions to which these proposals -- some of which raise extremely complex questions -- are entitled.

Recommendation 1. "Amending the 1966 Mental Health/Mental Retardation Act so that it specifically defines community to include persons in prisons and jails who are thus entitled to mental health services."

The MH/MR Act of 1966, 50 P.S. §4201 et seq. authorizes and mandates the Department of Public Welfare, through the county mental health and mental retardation program:

> "To assure within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them, regardless of religion, race, color, national origin, settlement, residence or economic or social status." (Emphasis added.)

The proposed legislation would presumably expressly prohibit any denial of services on the basis of an individual's detention or incarceration under the criminal justice system by adding prisoner status to the list of conditions that must be disregarded under the mandate of delivery of MH/MR services. The proposed legislation would clearly emphasize the right of prisoners to obtain services, but I bring to your attention the fact that there has been, to my knowledge, no official interpretation of the Act which excludes prisons or jails from the meaning of "residence or economic or social status" under the language quoted above. In the absence of specific inquiry and further study, I am not at this time rendering an opinion as to the extent of the present service mandate, and I do reserve judgment as to the necessity of the legislative change for any purpose other than to underscore an already existing right and duty.

Recommendation 2. "Amending Act 143 so that individuals incompetent to stand trial or found not guilty by reason of insanity, and thereafter involuntarily committed to a State hospital, are not released to the community without prior court action. Presently they are released when the director of the treatment facility determines they are no longer severely disabled nor in need of inpatient services."

Under Section 304 (g) (2) of Act 143, the Mental Health Procedures Act of 1976, 50 P.S. §7301 et seq. any individual who has been involuntarily committed is to be released whenever the director of a facility concludes that the person is no longer severely mentally disabled or in need of treatment. At the end of the court-ordered involuntary treatment, the court may, upon petition of the director of a facility or county administrator, order additional treatment. There must, however, be a finding of a need for continuing involuntary treatment. The Task Force recommendation would amend these release procedures so that those individuals acquitted of a criminal charge by reason of insanity, a small subset of the classification of individuals involuntarily committed, would be returned to court prior to their release. The larger class of those committed involuntarily without criminal charges would be released without court approval.

The proposed amendment may face constitutional attack insofar as it provides for release procedure and release standards for those individuals found not guilty by reason of insanity which differ from the standards and procedures applicable to other civilly committed patients. See Jackson v. Indiana, 406 U.S. 715 (1971). Baxstrom v. Herold, 383 U.S. 107 (1966). Furthermore, by predicating discharge upon a judicial finding of non-dangerousness to self or others in the reasonable future, the amendment directly conflicts with Act 143's general purpose and intent that involuntary commitment must be premised on a finding of severe mental disability and the medical necessity of further involuntary treatment.

I do not here predict the result of a constitutional attack on the proposed amendment. In U.S. v. Ecker, 543 F. 2d 178 (D.C. Cir., 1976), cert. denied, 429 U.S. 1063 (1977) differences in release procedures for those committed following acquital because of insanity and release of civil committees was held constitutionally permissable. However, the statutory scheme of civil commitment under the D.C. Code is not identical to the scheme in Pennsylvania and, therefore, the analysis of Ecker may not be applicable to the proposed amendment.

Recommendation 3. "Amending Act 143 to clearly permit emergency involuntary treatment in a prison setting without involuntary commitment even though the prison will not necessarily be designated a treatment facility."

The legislation contemplated by this recommendation would establish treatment standards and commitment procedures for individuals incarcerated or detained in correctional facilities which differ from the standards and procedures applicable to other mental health patients. It would presumably permit involuntary mental health treatment of prisoners under circumstances not meeting the requirements of Section 302 of Act 143 and under treatment conditions not approved by the County MH/MR Administrator or the Department of Public Welfare as required by Section 105 of Act 143.

To the extent that such legislation would authorize involuntary mental health treatment of prisoners in situations where similar treatment of other individuals would be prohibited, it may be vulnerable to constitutional challenge. See Jackson v. Indiana, 406 U.S. 751 (1971); Baxstrom v. Herold, 383 U.S. 107 (1966). I do not at this time predict the result of such a challenge.

Recommendation 4. "Passage of legislation to allow voluntary commitments from correctional settings to mental health settings."

It is my opinion that this legislative recommendation presupposes a negative response to the unanswered question of whether Act 143 permits voluntary admission to mental health facilities of persons confined in county jails or state correctional institutions. This question is raised by the language of Section 401 (a) of the Act which provides:

> "Whenever a person who is charged with a crime, or who is undergoing sentence, is or becomes severely mentally disabled, proceedings may be instituted. . . under the civil provisions of this act. . . ."
> (Emphasis supplied.)

"Severely mentally disabled" is defined in Section 301 and is the criterion for involuntary commitments under Sections 302-305. The standards for voluntary treatment are quite different; all that is necessary is that treatment be "medically indicated", (Section 206(c)), and that informed consent be obtained, (Section 201). Article IV of Act 143 makes no reference to voluntary treatment and it has been argued that this omission is significant and precludes mental health treatment of prisoners not meeting the involuntary treatment standards.

However, it is also true there are numerous cases which have held that prisoners are guaranteed life's basic necessities, including reasonable medical care as needed. See Estelle v. Gamble, 429 U.S. 97 (1976); Fritzke v. Shappell, 468 F. 2d 1072 (6th Cir. 1972). In addition, the Fourth Circuit has found, in Bowring v. Godwin, 551 F. 2d 44 (4th Cir. 1977), that there is no underlying distinction between the right to medical care for physical ills and their psychiatric or psychological counterparts. How far this right extends is uncertain since even Bowring limited this right to treatment to those cases which are "medically necessary." If Section 401 is read to limit mental health treatment of prisoners or detainees to those individuals who meet the "severely mentally disabled" standard, it would exclude psychiatric treatment of prisoners if such treatment was medically necessary, but yet not severe enough or not of such a nature to qualify within the §401 (a) standard. This would be contrary to Bowring which mandated psychiatric treatment where it was medically necessary. To arbitrarily exclude prisoners from voluntarily seeking medically necessary psychiatric treatment may violate the Eighth Amendment's prohibition of cruel and unusual punishment.

If the "severely mentally disabled" standard cannot constitutionally be applied so as to exclude voluntary prisoner transfers to mental health facilities, it is possible that § 401 (a) can be read to establish procedures for transfers only where psychiatric treatment was necessitated by a severe mental disability, rather than where treatment was medically necessary and available on a voluntary basis. In ascertaining the legislative intent of a statute, it is presumed that the General Assembly does not intend to violate either the State or Federal Constitutions. 1 Pa. C.S.A. § 1922(3). If § 401 (a) would be unconstitutional if it were read to preclude the voluntary transfer of those cases which are medically necessary, § 401 (a) must be read only to establish the procedures relating to involuntary placement, and the omission of "voluntary transfers" in Article IV could not be read to exclude a prisoner's constitutional right to voluntary treatment-- a right which is available to all persons under Article II of Act 143.

In the absence of specific inquiry and further study, I am not at this time rendering an opinion as to whether Act 143 precludes voluntary mental health treatment of prisoners. Until called upon to do so in my official capacity, I will reserve judgment on the question.

Recommendation 5. "Passage of legislation that provides for the Commonwealth to bear the cost of treatment for convicted individuals transferred from correctional settings to mental health facilities (presently charged to the county of conviction)."

This Legislative Recommendation represents a policy decision of the Task Force and in the abstract raises no legal or constitutional problems.

Recommendation 6. "Legislation clearly demonstrating the commitment of the General Assembly to the recommendations of this Task Force regarding Farview's future. This includes: a) timetable for closing Farview and developing multi-level units; b) providing the fiscal base; c) determining clear legislative intent as to location and size of the multi-level facilities."

This Legislative Recommendation represents a policy decision of the Task Force and in the abstract raises no legal or constitutional problems.

Recommendation 7. "The General Assembly must provide enabling legislation to establish multi-level security forensic units."

This Legislative Recommendation represents a policy decision of the Task Force and in the abstract raises no legal or constitutional problems.

VII. INFORMATION on COMMONWEALTH TRAVEL REIMBURSEMENT PROCEDURES

Reimbursement for Expenses of Members of DPW Boards, Committees and Commissions

Members of DPW Boards, Committees, and Commissions are reimbursed for necessary expenses in connection with the performance of their official dueits. Necessary expenses include reasonable charges for transportation, subsistence and related expenses including regisatration fees and representation expenses as an official (designated) representative of the Department.

Meals

Reimbursement is allowed for actual cost of meals if not covered by a contract, not to exceed $4.00 for breakfast, $6.00 for lunch, and $10.00 for dinner.

Lodging

Receipt for lodging cost must be submitted. Allowable rates: $15.50 (plus tax) per night in cities of less than 100,000 population; $19.00 (plus tax) per night within 25 mile radius of cities of more than 100,000 population, including Reading and Harrisburg.

Transportation

Use of personal car is reimbursed at rate of 16¢ per mile. Upon presentation of a receipt for airline, bus or railroad expenses is also reimbursed.

Reimbursement is allowed for miscellaneous expenses. Receipts must be furnished for turnpike tolls, parking or overnight car storage, and taxi fare over $10.00.

Please return to Mrs. Margaret Underkoffler, Room 303, Health and Welfare Building, Harrisburg, Pennsylvania. 17120, Telephone Number Area Code 717 - 787-1947.

TRAVEL EXPENSE VOUCHER

NUMBER 1761005

IOTE: On completion of this side of form, snap carbons out and use for completing reverse side.

MPLOYE'S NAME (PRINT CLEARLY)	CLASS TITLE	VOUCHER NO.	CONTROL NO. (COMPTROLLER ONLY)
MPLOYE'S SOCIAL SECURITY NO.	BARGAINING UNIT CODE		
GENCY	HEADQUARTERS		
ESIDENCE STREET ADDRESS	DELIVER CHECK TO (STREET ADDRESS)		
ITY AND STATE ZIP CODE	CITY AND STATE ZIP CODE		

FUND	DEPT	APP	YEAR	LOG	ORG	COST CENTER	OBJ		PPB SUB CATG	PPB ELEM	AMOUNT

FOR THE PERIOD

FROM ______________ TO ______________
(MO-DAY-YR) (MO-DAY-YR)

ATE	ITINERARY TIME LV	ITINERARY TIME RET	ITINERARY LIST LOCATIONS	TRANSPORTATION PERS. AUTO MILES	TRANSPORTATION NAME OF CARRIER & T. O. NUMBER	TRANSPORTATION CASH YOU PAID TICKET	TRANSPORTATION CASH YOU PAID LOCAL	LODGING NAME OF HOTEL & H. O. NUMBER	LODGING CASH YOU PAID	SUBSISTENCE CASH YOU PAID	MISCELLANEOUS EXPENSES EXPLANATION	MISCELLANEOUS EXPENSES CASH	TOTAL
					TOTAL								$

RSONAL AUTO

______ MILES @ ______ ¢ = $ ______

______ MILES @ ______ ¢ = $ ______

TOTAL PERSONAL AUTO ALLOWANCE ——→ $ ______

I CERTIFY THAT THE STATEMENTS AND EXPENSES CLAIMED ARE CORRECT, REASONABLE AND WERE INCURRED IN THE PERFORMANCE OF COMMONWEALTH DUTIES.

______________ EMPLOYE SIGNATURE AND DATE

______________ SUPERVISOR SIGNATURE AND DATE

PERSONAL AUTOMOBILE ALLOWANCE $

TOTAL REIMBURSEMENT CLAIMED BY YOU $

5. EMPLOYE/WORK COPY

VIII. NAMES AND ADDRESSES OF DPW SUPPORT STAFF

DEPARTMENT OF PUBLIC WELFARE

SUPPORT STAFF

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